York Teaching Hospital NHS
NHS Foundation Trust

The programme for the next meeting of the Trust's Board of Directors day, which will take place:

on: **Wednesday 27th January 2016**

in: **The Boardroom, York Hospital, Wigginton Road, York**

Time	Meeting	Location	Attendees
8.15am – 8.55am	Non-Executive Director Meeting with Chair	Patrick's Office, 2nd Floor Admin Block, York Hospital	Non-executive Directors
9.00am – 1.00pm	**Board of Directors meeting held in public**	**Boardroom, 2nd Floor Admin Block, York Hospital**	**Board of Directors and observers**
1.00pm – 1.30pm	Lunch in the Boardroom	Boardroom, 2nd Floor Admin Block, York Hospital	Board of Directors
1.30pm - 4.15pm	Board of Directors meeting held in private	Boardroom, 2nd Floor Admin Block, York Hospital	Board of Directors

The values of the Trust are:

- **Caring about what we do**
- **Respecting and valuing each other**
- **Listening in order to improve**
- **Always doing what we can to be helpful**

…with patients at the centre of everything we do

These will be reflected during all discussions in the meeting

York Teaching Hospital NHS
NHS Foundation Trust

The next meeting of the Trust's Board of Directors held in public will take place

On: **Wednesday 27th January 2016**

At: **9.00am – 1.00pm**

In: **The Boardroom, York Hospital, Wigginton Road, York**

A G E N D A					
No	**Time**	**Item**	**Lead**	**Paper**	**Page**
Part One: General					
1.	9.00-9.05	**Welcome from the Chairman** The Chair will welcome observers to the Board meeting.	Chair		
2.		**Apologies for Absence and Quorum**	Chair		
3.		**Declaration of Interests** To receive any changes to the register of Directors' declarations of interest, pursuant to section 6 of Standing Orders.	Chair	A	7
4.		**Minutes of the Board of Directors meeting held on 16 December 2015** To review and approve the minutes of the meeting held on 16 December 2015.	Chair	B	11
5.		**Matters arising from the minutes** To discuss any matters arising from the minutes.	Chair		
6.	9.05-9.15	**Patient Story** Kathryn Sartain, Lead Nurse for End of Life Care to present the 7 day palliative care service.	Lead Nurse for End of Life Care	Verbal	
7.	9.15-9.40	**Chief Executive Report** To receive an update on matters relating to general management in the Trust.	Chief Executive	C	21

No	Time	Item	Lead	Paper	Page
Part Two: Quality and Safety					
8.	9.40-10.45	**Quality and Safety Performance issues** To be advised by the Chair of the Committee of any specific issues to be discussed. • Patient and Quality Safety Report • Medical Director Report • Chief Nurse Report • Safer Staffing • Patient Experience Q3 report (for information)	Chair of the Committee	D D1 D2 D3 D4 D5	27 37 71 77 89 101
9.		**Director of Infection Prevention Control quarterly Report** To receive the quarterly report.	Chief Nurse	E	111
10.45 - 11.00		**Coffee break**			
Part Three: Finance and Performance					
10.	11.00-11.35	**Finance and Performance issues** To receive a summary of the discussions at the meeting framework from the Turnaround Avoidance Programme – Delivering Success. • Finance Report • Efficiency Report • Performance Report	Chair of the Committee	F F1 F2 F3	119 133 153 159
11.	11.35-11.55	**Annual Plan** To receive information about the development of the Annual Operational Plan for 2016/17.	Director of Finance	Verbal	
Part Four: Workforce					
12.	11.55-12.20	**Minutes from the Workforce Strategy Committee** To receive the minutes from the meeting held on 8 December 2015.	Chairman of the Committee	G	169

No	Time	Item	Lead	Paper	Page
13.		**Workforce Metrics and Update Report** To receive a report updating the Board on HR issues.	Chief Executive	H	179
Part Five: Environment and Estates Committee					
14.	12.20-12.30	**Minutes of the Environment and Estates Committee** To receive the minutes from the meeting held on 15 December 2015 and approve the Sustainable Development Report.	Chairman of the Committee	I	189
Part Six: Community					
15.	12.30-12.40	**Update on progress to transfer Community Services at Whitby to Humber FT** To receive an update on progress against the transfer.	Director of Out of Hospital Services	J	263
Part Seven: Governance					
16.	12.40-1.00	**Governance Documents** The Board is asked to approve the Reservation of Powers and Scheme of Delegation, Standing Orders, Standing Financial Instructions.	Foundation Trust Secretary	K	267
17.		**Business Case** To consider and approve the business case 2015-16/32 - Development of Theatre 10.	Director of Finance	L	367
18.		**Monitor Quarterly Return** To consider and approve the quarter 3 return to be sent to Monitor.	Director of Finance	M	383
Any Other Business					
19.		**Next meeting of the Board of Directors** The next Board of Directors meeting held in public will be on 24th February 2016 in the Boardroom, York Teaching Hospital.			

20.		**Any other business** To consider any other matters of business.

Items for decision in the private meeting:

There are no specific decisions to be taken in the Private meeting.

The meeting may need to move into private session to discuss issues which are considered to be ‘commercial in confidence’ or business relating to issues concerning individual people (staff or patients). On this occasion the Chair will ask the Board to resolve:

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.

Register of directors' interests
January 2016

York Teaching Hospital NHS
NHS Foundation Trust

Additions: No changes

Changes: No changes

Deletions: No changes

A

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS founda-
Ms Susan Symington (Chair)	**Non-executive Director—**Beverley Building Society **Director** - Lodge Cottages Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Jennifer Adams (Non-Executive Director)	**Non-executive Director** Finance Yorkshire PLC	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Philip Ashton (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Member of the Board of Directors—** Diocese of York Education Trust	Nil	Nil
Ms Libby Raper (Non-Executive Director)	**Director—**Yellowmead Ltd	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Governor** —Leeds City College **Chairman and Director -** Leeds College of Music **Member—**The University of Leeds Court	Nil
Michael Keaney (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Mr Michael Sweet (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Professor Dianne Willcocks (Non-Executive Director)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity **Trustee and Vice Chair—**of the Joseph Rowntree Foundation and Joseph Rowntree Housing Trust **Chair—**Advisory Board, Centre for Lifelong Learning University of York **Member—**Executive Committee YOPA **Patron—**OCAY **Chairman** - City of York Fairness and Equalities Board **Member –**Without Walls Board	**Director—**London Metropolitan University **Vice Chairman—**Rose Bruford College of HE	Nil
Mr Patrick Crowley (Chief Executive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Director	Relevant and material interests					
	Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).	Ownership part-ownership or directorship of private companies business or consultan-cies likely or possibly seeking to do business with the NHS.	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services or com-missioning NHS services	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks
Juliet Walters (Chief Operating Of-ficer)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Andrew Bertram (Executive Director Director of Finance)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	**Member** of the NHS Elect Board as a member representa-tive	Nil
Mr Mike Proctor (Deputy Chief Execu-tive)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Spouse a senior member of staff in Community Services	Nil
Beverley Geary (Chief Nurse)	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Dr Ed Smith Interim Medical Di-rector	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil
Mr Jim Taylor Interim Medical Di-rector	Nil	Nil	Nil	**Act as Trustee** –on behalf of the York Teaching Hospital Charity	Nil	Nil

Minutes of the meeting of the Board of Directors of York Teaching Hospital Foundation Trust, held in public in the Boardroom York Hospital on 16 December 2015

Present:	**Non-executive Directors**	
	Ms S Symington	Chairman
	Mrs J Adams	Non-executive Director
	Mr P Ashton	Non-executive Director
	Mr M Keaney	Non-executive Director
	Ms L Raper	Non-executive Director
	Mr M Sweet	Non-executive Director
	Professor D Willcocks	Non-executive Director
	Executive Directors	
	Mr A Bertram	Director of Finance
	Mrs B Geary	Chief Nurse
	Mr M Proctor	Deputy Chief Executive
	Mr J Taylor	Medical Director
	Mrs J Walters	Chief Operating Officer
	Corporate Directors	
	Mr B Golding	Director of Estates and Facilities
	Mrs S Rushbrook	Director of Systems and Networks
	Mrs W Scott	Director of Out of Hospital Services
In Attendance:		
	Reverend Martin Doe	Chaplin (for item 15/189)
	Reverend Andrew Foster	Chaplin (for item 15/189)
	Mrs A Pridmore	Foundation Trust Secretary
Observers:	Mrs M Jackson	Public Governor – York
	Mrs P Worsley	Public Governor – York
	Mr J Cooke	Public Governor – York
	Mr R Wright	Public Governor – York
	Mrs L Provins	Membership and Governor Manager

The Chairman welcomed the Governors and members of staff to the meeting.

15/186 Apologies for absence

Apologies were received from Mr P Crowley, Chief Executive

The Chair asked Mrs Pridmore to confirm the meeting was quorate. Mrs Pridmore confirmed the meeting was quorate. Ms Symington congratulated Mr Sweet on his reappointment as a Non-executive Director. She advised that the Council of Governors had confirmed his reappointment at their last meeting on 9 December 2015.

15/187 Minutes of the meeting held on the 25 November 2015

The minutes were approved as a true record of the meeting.

15/188 Matters arising from the minutes

Mr Bertram updated on the action to provide a summary of the spending review and confirmed that he had circulated a summary published by NHS Providers.

15/189 Declarations of interest

The Board noted the declarations of interest. There were no additional changes.

15/190 Patient Story

Ms Symington welcomed the Chaplains, Reverend Andrew Foster and Reverend Martin Doe to the meeting. She spoke about the importance of the role of the Chaplains in the organisation, particularly in their support of the patients, staff and the wider community and explained that she was keen to raise the profile of the Chaplaincy.

Reverend Foster spoke about his role in the organisation and gave an overview of its extent. He talked about how patients can seek his support from a spiritual, religious or independent perspective and he gave a number of examples. He specifically talked about the support the Chaplaincy gives to overseas visitors and described some of the support that had recently been given to a family following the funeral of a baby

Reverend Foster talked about the institutional support his team provides. He talked about the work undertaken with patients following the closure of the Mental Health Unit in Bootham Hospital and the work his team is involved with around the end of life pathway.

Reverend Doe talked about the volunteer service which supports the Chaplaincy. He reported that 40 volunteers have made 1400 visits over the last month across the Trust. With this support the Chaplaincy is able to provide services to many more patients and family members.

The Chaplains described the wider community work they are involved with in schools and 6th form colleges. They talked about the carol services, working with students around medical ethics and the Christmas drop-in sessions that are currently being held.

Mr Proctor added that in his view the service is very unique, is available to all and cuts across different faiths. He expressed his support for the service and thanked the Chaplains for everything they do.

Reverend Foster read a brief blessing.

The Board thanked the chaplains for their presentation and for the very important role they undertake in the organisation.

15/191 Report from the Chief Executive

Mr Proctor reported that the CQC action plan and report had recently been presented to the Health Scrutiny Committee and the Health and Wellbeing Board. He added that Hull

NHS Trust also presented their CQC report to the Health and Wellbeing Board and he was struck by the fact that the report described both organisations as “requires improvement” and that there were significant differences in the individual ratings which demonstrated the wide variation in reported quality covered by this overall rating.

Mr Proctor confirmed that two actions had been completed during November in line with the CQC action plan. They were

- *The provider must ensure that patients’ privacy and dignity is maintained when being cared for in the bays in the nursing enhanced unit based on ward 16 at York hospital to the up to date requirements and good practice.*
- *The provider must ensure that patient records are fully secured when stored, specifically within the school nursing records.*

The Board noted the update.

Mr Proctor referred to the arranged cover for clinical services over the Christmas period and assured the Board of the quality of the plans. He added that discussions, particularly around improving unscheduled care, are continuing with colleagues in the wider local health system, but currently not all issues have been resolved. The level of co-operation with Social Services and the CCGs is very good.

Ms Raper asked Mr Proctor for any new information he may have about the Junior Doctor Contract discussions. Mr Taylor reminded the Board that the strike that was planned for the beginning of December had been suspended and at present negotiations continue between the Government and the General Medical Council through ACAS. He felt this did imply the possibility of a settlement between the parties. He added that the Consultant contract discussions have reached a similar stage.

Ms Symington asked and the Board considered if it was possible for the Trust to lead some of the discussion locally. Mr Taylor felt this would not be possible as the issues were part of a national debate. Mr Proctor added that it would be difficult as the Trust does need to be sensitive to the Junior Doctors’ position around terms and conditions to be included in their contract. Mr Proctor linked the discussions to the development of a 7 day service. He explained that discussions had been held with consultants locally and requests have been made to ask them to work within a 7 day service, in the same way as nurses are required to cover the service 24 hours a day, 7 days a week by shift work.

The Board recognised the context within which the current negotiations are taking place (public pay freezes and recent changes to pensions) and hoped for a speedy and positive result to the negotiations.

15/192 Briefing on current issues from the Medical Director and Chief Nurse

Nursing Update

Mrs Geary presented an update on Infection Prevention Control. She reminded the Board that the annual trajectory for cases of C-Diff is 48 and advised that currently the Trust has reported 47 cases (as at 16 December 2015). Mrs Geary advised that Post Infection Reviews (PIR) were being held for all cases. It had been agreed that 9 cases were not due to lapses in care, the other cases remaining under review.

Mrs Geary reported that Ward 32 was currently closed due to an outbreak of Norovirus. She reminded the Board that there had been a significant outbreak during October. Since then, the Trust had continued to see cases of Norovirus which had closed bays, but not wards.

Mrs Geary updated the Board on progress against the infection prevention control action plan following the internal governance review of infection prevention control. She advised that as of January 2016 the newly formed Hospital Infection Prevention Control Group (HIPCG) would be in place. This will be an executive led forum. New Terms of Reference and group membership is in the process of being agreed.

Mrs Geary updated the Board on the nurse staffing position. She advised that 65.7 registered nurses would be joining the organisation over the next few weeks, of which 6 from the EU started in December and the rest will join the Trust in January.

Mrs Geary described the other activities being undertaken around the recruitment of nursing staff, including generic recruitment events, early interviews with 3rd year students and continued recruitment efforts in the EU. She added that EU recruitment was becoming more difficult as demand continues to be high from the NHS in England and in January the new English language test will be introduced.

The Board asked if the attrition rate for nurses had now slowed. Mrs Geary confirmed the attrition rate had slowed over recent months.

Medical Director Update

Mr Taylor updated the Board on the work to improve job planning for consultants. He reported that the intention was to revise the approach, go back to the basic guidelines and ensure that there was a tighter grip and more strategic control over the process. The first version of the policy would be considered by the Executive Board at its meeting in January and will be published and accessible to all. The Board asked about the level of engagement with the Clinical Directors around the development of the first draft. Mr Taylor explained that the Clinical Directors will be asked for their engagement as part of the discussion at the Executive Board meeting. All Clinical Directors will be asked to comment on the first draft of the document.

The Board was assured by the developments outlined by Mr Taylor. Mrs Adams asked if this work would provide some clarity around the amount of Supporting Professional Activity (SPA) time in each Directorate. Mr Proctor commented that there are challenges involved in identifying SPA time and Direct Clinical Care (DCC) time.

Professor Willcocks commented that the Workforce Strategy Committee would continue to maintain oversight of the work.

15/193 Finance and Performance Committee

Ms Symington invited Mr Keaney to lead this section of the agenda. Mr Keaney advised that the Committee was not scheduled to have a meeting in December, but due to the challenges around performance and finance it had been agreed by the Committee that a December meeting was required.

Mr Keaney reminded the Board of the real concerns of the Committee, specifically around performance and the financial position of the Trust. He invited Mrs Walters and Mr Bertram to update the Board.

Performance

Mrs Walters summarised the performance in November and noted the deterioration in the position. She reported there had been a 6% increase in non-elective admissions (220 patients) compared to the same period last year and a significant increase in urgent admissions from GPs (18% York, 55% Scarborough), all of which resulted in elective admissions being cancelled. She also highlighted that a significant number of patients requiring Section 5s referrals had their transfer from hospital delayed and as a result there had been 922 bed days lost across the Trust.

Mrs Walters updated the Board on the actions that have been taken following the meeting with Monitor and the CCG.

York

Mrs Walters reported that immediate action has been focused on the 'out of hours' and the provision of service by Yorkshire Doctors. As a result of the discussions, Yorkshire Doctors are now providing a service in the evening on a Monday and Friday and weekends at York. This is an interim position and discussions continue to seek a 7-day solution.

Referring to the streaming of patients in the Emergency Department, the Board was reminded that the Trust was required to implement a different streaming system by the CQC following their visit in March 2015. Their approach had a direct, but unintentional impact on non-admitted breaches. As a result and following a discussion with Emergency Care Intensive Support Team (ECIST) the Trust has amended the streaming process. Mrs Walters reported that this change in streaming of patients has had a positive impact on the level of non-admitted breaches.

Mrs Adams asked for assurance that the change does not compromise patient safety. Mrs Walters confirmed the changes do not compromise patient safety and explained that the change is supported by governance arrangements and is clinically led.

Mrs Rushbrook supported Mrs Walters in her comments and reminded the Board that Monitor has a number of qualitative standards that the Trust is required to comply with including, the length of time to see a doctor and the number of patients leaving the department without being seen. She confirmed there has recently been a reduction in the length of time it takes to see a doctor and there has been a reduction in the number of patients leaving the department before being seen.

Ms Raper asked for a document to be presented to the Quality and Safety Committee that clearly outlined the changes around streaming patients in the Emergency Department.

Action: Mr Taylor to present a paper to the next Quality and Safety Committee that clearly documents the changes around streaming patients in the Emergency Department.

Mrs Walters added that currently the “Discharge to Assess” pathway is being piloted in January and, when implemented, should have a positive impact on reducing delayed discharges. Wendy Scott was leading on discussions with the LA and CCGs.

The Trust has arranged a Safer Start event in January with Social Services and the Vale of York CCG to discuss delayed transfer of care. It is intended that this event will be an opportunity to improve the current position.

Discharge Liaison Officers are also being trialed at York by using non-clinical staff on a voluntary basis. The Board understood that this was a role introduced in Scarborough and deals with the administration of the discharge of a patient and their introduction has demonstrated that the role is effective.

Scarborough

Mrs Walters reported that the lack of intermediate care provision was identified as an issue some time ago. At a recent meeting Monitor highlighted to the CCG how important the introduction of intermediate care was to the system and pressed the CCG to progress the provision. Mrs Walters reported that at present this has not been progressed by the CCG.

Mrs Scott updated the Board on an event to be held in the near future addressing the intermediate care issues with the CCGs, Community Services and Therapists and suggested that it could be an opportunity to discuss the requirements in a different forum.

The Board asked if there were any further developments with Monitor. Mrs Walters advised that a follow-up discussion has been held with Monitor and at this stage they have been assured by the progress that has been made by the Trust.

In terms of additional capacity, Mrs Walters explained all available capacity was being used at Scarborough and Bridlington and that the Winter Plan was intended to manage pressure. It was noted that Bridlington was continuing to be used for elective procedures, which was proving effective.

Mrs Walters reported that it had been agreed with Monitor that the minimum expected level of performance is 90% against the 4 hour Emergency Care Standard target by the end of quarter 4. It was noted the previous week’s emergency care performance (for one week) was 91.65%.

Mrs Walters concluded by saying that improvements are being seen, but it is early days and every effort is continuing to be made to ensure sustainability and further improvement.

Mrs Scott advised the Board that ECIST had reviewed the community units and would be providing formal feedback over the next few weeks. In their early feedback they did note that access to equipment was difficult and that there were recent concerns around the ability of the Trust to access fast track funding.

Finance

Mr Bertram commented that the financial position is disappointing. The underlying income and expenditure position has moved from a £7.3m deficit to an £8.3m deficit and the

variance from plan has increased from £5.2m to £6.3m. A technical charge of £4.6m has been made for transferring the ownership of Whitby Hospital to NHS PropCo. This charge is excluded in any Monitor assessment.

Mr Bertram advised that expenditure remains at consistently lower levels than the peaks reported earlier in the year, but is still too high. He advised that there have now been three months where expenditure has been reduced, but he was hoping to see further reduction in expenditure in part due to the additional measures put in place around discretional spend.

The key difference in the November reports is the continued loss of elective activity as a result of increased non-elective admissions and GP admissions. The early data for December suggests that there has been an improvement in this position along with a reduction in cancelled operations. The challenges around theatre staffing reported last month are being addressed through recruitment and additional payments made to staff and, as a result, more theatre lists have been arranged.

In terms of cash, Mr Bertram referred the Board to the cash balance forecast and noted that the current cash position is running between the 'base forecast' and the 'downside case'. To improve the cash position, a significant programme related to debt recovery has been put in place, including using a debt collection agency for non-NHS debts.

He added that if the situation continues there is a risk that the £10m strategic capital could be affected and the Trust would need to use some of the capital for operational purposes. Mr Bertram added that Mr Crowley had met with Mr Jim Mackey (CE NHS Improvement) to discuss the issue.

Mr Bertram outlined the forecast outturn position. He felt that it was possible that the Trust would exceed a year end deficit position of £12m. He explained that if this was an accurate forecast, it would impact on the quarterly declaration submitted to Monitor. The Financial Risk Rating would drop to 2 which could result in Monitor taking formal action against the Trust. He proposed that in those circumstances the Board should hold a further detailed discussion.

The Board noted the comments and the risks identified by Mr Bertram.

Mr Bertram referred to the national context and the recent National Audit Office (NAO) report which highlighted the continued deterioration of provider finances in the NHS. He explained that the report called for systemic intervention and described the current action as not sufficient. He commended the report to the Board.

Mr Bertram referred to 2016/17 onwards and suggested that the Trust would receive information on the tariff for 2016/17 in the next few weeks. His understanding is that there will be a better financial settlement this year with a 3% inflation element and a reduced efficiency saving requirement of 2%. He added that in his view next year the Trust needs a period of stabilisation and a positive release of cash for transformation will help achieve that.

Ms Symington thanked Mr Bertram for his report and asked the Executive Directors to comment.

A number of the Executive Directors provided comment. They agreed that some stabilisation of finance and services was required. The strategy adopted by the Trust around the Cost Improvement Programme means that the quality and safety of patients is not compromised and providing 24 hour 7 day a week care in the current financial envelope will be difficult.

Mr Bertram added that it is difficult for commissioners to deliver their required savings and the Trust should remain cognisant of that.

The Trust has a history of delivering the CIP, in the last 6 years it has delivered over 4% each year. This year as at the end of November, the Trust has delivered 75% of the £26m target and is on track to deliver the full programme by the end of the year.

Mr Sweet asked Mr Bertram for assurance about any risk there might around CCG paying Trust invoices. Mr Bertram advised that the Trust is starting to see the 3 main CCGs increase the level of challenge around invoices. Some of the questions being raised are around specific pathway charges, but there has also been a request from Scarborough and Ryedale CCG (SRCCG) to place a cap on outpatient activity for the rest of the year. He advised that the Corporate Directors were working with the CCG, but had rejected the notion of a cap. The Corporate Directors have reminded the CCGs of the existing conditions register to SRCCG and discussions are continuing. Mr Bertram confirmed at present he is assuming that all CCGs will continue to honor their commitments.

The Board discussed the work that had been undertaken a few years ago around the development of the conditions register and understood that if the CCG can identify a pathway that would ensure a patient could safely receive care in the community they would remove the condition from the register.

Mr Keaney added that one of his specific concerns was around the workforce stream in the Turnaround Avoidance Programme (TAP). He recognised that significant work had been undertaken, but felt there was still much to do. He highlighted the impact workforce issues have on the Trust from a performance and finance perspective. He felt that 80% of the issues relate to workforce and if those could be resolved a lot of the issues would be addressed.

Mr Proctor added that there are national issues around workforce which cannot be resolved by the Trust. He also expressed the view that there are broader discussions that need to be held across the Trust that affect workforce. Solutions need to be found for some of the more complex areas.

Ms Symington commented that the messages from the recent Chairs and Chief Executive's meeting had started to articulate the need for stabilisation and she felt a direction of travel is emerging.

The Board noted the progress and the comments made.

15/194 Community Services

Mrs Scott presented the proposed pilot of a "Discharge to Assess" model that has been agreed via the local Scarborough and Ryedale and Vale of York Systems Resilience Group. She described the model and the benefits of implementation. She explained that

it will have significant implications for the way discharges from hospital are managed. It is anticipated that the pilot will test out the D2A concept and provide important information that will inform a future business.

The Board noted the report and was supportive of the pilot and the benefits it would bring to patients.

15/195 Next meeting of the Board of Directors

The next meeting, in public, of the Board of Directors will be held on 27 January 2016, in the Boardroom, York Teaching Hospital

15/196 Any Other Business

Ms Symington invited members of the Board to the Christmas lunch that was being held for the Volunteers on 17 December in the Boardroom at 12.30pm.

Ms Raper asked for it to be noted that she had been impressed by the new governance arrangements in place in Obstetrics and Gynecology Directorate and thanked Mrs Pridmore for her contribution.

Outstanding actions from previous minutes

Minute number and month	**Action**	**Responsible officer**	**Due date**
15/087 Diverse Workforce	A proposal around investment in training for specialist and middle grade doctors in the future to be presented to the Board when developed	Mr Crowley	future
15/114 Quality and Safety Committee	Present a progress paper on the Implementation of the Nursing and Midwifery Strategy	Mrs Geary	January 2016
15/117 Community Care update	Provide further detail on the re-ablement discussions when available. Include the issue arising from the review of the re-ablement service from the system leadership discussions.	Mrs Scott Mrs Walters	When available Report to Board when completed
15/147 Food and Drink Strategy	The Board agreed to test the quality of food on an annual basis.	Mr Golding	31 March 2016

15/147 Food and Drink Strategy	Feedback to the Board on the use of volunteers in the provision of a beverage service to inpatients.	Mrs Geary	January 2016
15/163 Winter Plan	Review the Winter Plan	Mrs Walters	March 2016
15/164Workforce Metrics and update report	Incorporate the pay expenditure table into the performance report.	Mrs Rushbrook	Immediate
15/175 CQC report and action plan	A paper outlining progress against the CQC action plan to be presented to the March 2016 meeting	Mr Crowley	March 16

Action list from the minutes of the 16 December 2015

Minute number	**Action**	**Responsible office**	**Due date**
15/192 Finance and Performance Committee	Present a paper to the January Quality and Safety Committee that clearly documents the changes around streaming patients in the Emergency Department.	Mr Taylor	January 2015

C

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Chief Executive's Report

Action requested/recommendation

The Board is asked to note the report.

Summary

This report provides an overview from the Chief Executive.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☒

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC regulations

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	No risk.

Resource implications	No resource implications.
Owner	Patrick Crowley, Chief Executive
Author	Patrick Crowley, Chief Executive
Date of paper	January 2016
Version number	Version 1

Board of Directors – 27 January 2016

Chief Executive's Report

1. Chief Executive's Overview

I am conscious that by the time we meet formally we will have had our time out, at which we will have re-visited our mission and purpose and considered our emerging priorities in the context of the various planning and technical guidance for 2016/17-2020/21 that has emerged in recent weeks. I will endeavour to capture the key outcomes of this work at Board, however, I thought it prudent to summarise the various communications received to date for the record and for public consumption.

There have been several significant announcements in January, following the Comprehensive Spending Review in December 2015. The headline for the NHS in relation to the CSR was a confirmed extra £10bn by 2020/21, with the focus being on delivery of seven-day services and increased access to GPs in the evenings and at weekends.

Jim Mackey, Chief Executive-designate of NHS Improvement, and Professor Sir Mike Richards, CQC's Chief Inspector of Hospitals, have written to all Trusts, asking us to equally consider quality and finance in our planning and decision making. A key point in this letter is that Monitor, CQC and NHS England, will jointly be publishing revised staffing guidance and a new metric looking at care hours per patient day, as part of CQC's new assessment on the use of resources. We expect further details on this will be published in the coming months.

Individual letters have been sent by NHS Improvement to Trusts highlighting their indicative share of the £1.8bn sustainability fund. This funding will be dependent on meeting set criteria, including compliance with the rules around agency staffing, progress towards seven day working, and clear performance, sustainability and transformation plans.

A general component of the fund will be allocated to Trusts based on the proportion of their emergency services, as reported in the 2014/15 reference cost collection, and our lead CCG will share with us the indicative level of payment. We must then confirm whether or not we accept this and the associated conditions. I will keep the Board updated on this topic.

Preliminary recommendations from Lord Carter's review in to operational productivity have been released, with the full report expected in the next month or so. Lord Carter states that the NHS will be able to generate £5bn of efficiency savings by the end of the Parliament, but only with specific support, for example in addressing delayed transfers of care, and substantial improvements in workforce productivity.

Finally, NHS Improvement has outlined additional arrangements regarding agency costs. It restates the plan to lower the agency price caps for medical and clinical staff, and extends the ban on non-approved agency frameworks to all staff groups.

NHS Improvement states that it will, in time, move towards expressing price caps in a way that defines the amount the worker receives – equivalent to standard NHS terms and conditions – and agencies will bid to be on-framework on the basis of their agency fees. The letter also states that there will be a requirement for providers to use e-rostering.

Yorkshire floods

As Board members will be aware (and some may have experienced first-hand) the recent flooding caused major disruption to many parts of the country, at a time when NHS services are traditionally at their most pressured.

We experienced particular issues in Tadcaster, where the health centre flooded, and our phone systems were also affected due to simultaneous flooding at the Leeds Vodaphone and York BT exchanges. As is always the case in these circumstances, it was great to see the way that staff put patients and colleagues first and made sure that the floods caused minimal disruption.

I want to thank everyone who played their part during the flooding and I hope for a swift return to normal business for those areas most affected.

Emergency planning

In early December Dame Barbara Hakin, National Director of Commissioning Operations at NHS England, wrote to all Trusts regarding our preparedness, and that of the NHS at large, for a major incident. As part of this we are required to make several assurances to our Board of Directors as part of a public Board meeting.

As a Trust we have a major incident plan and various local business continuity plans. The major incident plan has recently been reviewed and updated, and the Trust's Emergency Planning Steering Group, comprising key operational leads, meets regularly.

We have reviewed and tested our communications cascade systems and remain confident that the processes we have in place are appropriate for contacting staff in the event of a major incident. This was tested by the recent flooding when the Leeds Vodaphone and York BT exchanges were out of action, giving us the opportunity to review our reliance on single providers. Whilst we have followed good practice in terms of having multiple providers for our communications systems, it became apparent that there is a reliance by other providers on the BT network. Systems and Network Services are talking to our suppliers about possible options. During the floods our teams were able to restore communications systems quickly.

Given the range of community and acute services we provide across the county, we have plans in place to ensure that staff can gain access to our sites during periods of disruption to the transport infrastructure. We have good partnership arrangements with the Police and the Local Authorities, and recent events such as the Tour de France and Tour de Yorkshire have helped us to embed this way of working and ensure that community staff can continue to provide services to patients in their homes. The floods in late 2015 caused minimal disruption to staff attending work, and although community services were particularly challenged in some parts of the patch, working alongside emergency services meant that our staff were able to visit all patients.

Arrangements are in place for a major incident and we have agreed with the Critical Care Network that we can increase our critical care capacity by up to 100% if required. Discussions are taking place with the Major Trauma Network as to how we can work more closely together to support further increased capacity, or a protracted period of increased demand, in response to an incident.

As a trauma centre supporting the Major Trauma Unit in Hull, we took part in an emergency preparedness event in December 2015, where the issue of how the Trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistics injuries was raised and discussed. The availability of a national helpline is being discussed, and work between our major trauma centre in Hull and colleagues at

University Hospitals Birmingham is actively being progressed. A further event to help trauma centres prepare for incidents involving casualties of this nature is being planned by the National Clinical Director for Trauma, and the Trust will be represented. The ability to set up additional recovery areas on our sites has been agreed through Yorkshire Ambulance Service, as they are in a position to establish increased capacity and staffing through MERIT (the Medical Emergency Response Incident Team), which is part of the Major Trauma Network response.

Sale of Groves Chapel

As Board members will recall, we have been making efforts to progress the sale of Groves Chapel, a Grade 2 listed building owned by the Trust and sited adjacent to York Hospital. The former Wesleyan Chapel is in a very poor state of repair and has been used for many years as office accommodation, storage and as a training facility. The Capital Programme Executive Group approved the acceptance of a conditional offer from Harrison Developments. This offer was made and accepted based on planning application expectations. Following discussions with City of York Council, the full application has required variation, reducing the number of dwellings on the site. This has resulted in an 8% reduction in the offer. Board members are asked support the continuation of the sale.

In the news

The continuing dispute between the Government and junior doctors attracted media interest, for both the cancelled action pre-Christmas and the action that went ahead in January. As is to be expected, the main focus of the media interest from the Trust's perspective was on the impact of the action.

We gained positive local press coverage with stories of staff working over Christmas, and also of the many donations from local businesses and individuals to our hospitals for the benefit of patients who are in hospital during this time.

Positive coverage was also gained in relation to the new hepatology service and the cystic fibrosis unit.

We saw less interest in 'winter pressures' than in previous years, no doubt due in part to the floods.

I have also recorded an interview with BBC Look North for a piece on NHS finances in our region, exploring the projected collective deficit of around £100m across the 12 hospital Trusts in Yorkshire.

2. Recommendation

The Board is asked to note the report.

Author	**Patrick Crowley, Chief Executive**
Owner	**Patrick Crowley, Chief Executive**
Date	**January 2016**

Blank page

York Teaching Hospital NHS Foundation Trust

Quality & Safety Committee – 19th January 2016 Boardroom, York Hospital

Attendance: Jennie Adams, Libby Raper, Philip Ashton, James Taylor, Beverley Geary, Anna Pridmore, Liz Jackson

	Agenda Item	Comments	Assurance	Attention to Board
1	**Last meeting notes dated 17 November 2015**	The minutes were approved as a true and accurate record.		
2	**Matters arising**	The Committee discussed the governance structure of Groups reporting in to the Committee. JT confirmed that the Chair of the Patient Safety Group will report to the Committee through him. BG confirmed that any assurance from the Nutrition and Hydration Group will be escalated through her when needed. A centralised trust wide action plan has been devised for falls and pressure ulcers and will focus on areas of high risk. The Committee look forward to receiving this as part of the quarterly reports. BG confirmed that the female genital mutilation training focused on Maternity, Gynaecology and Paediatrics and is complete for nursing staff. Training of Medical Staff is captured in a different way and numbers are being looked in to, BG will update at the next meeting. All other actions are covered on the agenda.		

	Agenda Item	Comments	Assurance	Attention to Board
3	**Risk Register for the Medical Director and Chief Nurse**	The Committee reviewed the updated Risk Registers and queried why the lower ranked risks were not included. AP confirmed that any risks rated below 12 are included and managed on the Directorate risk registers. The Committee drew its attention to the difference in risk rating between nursing and medical staffing. JT explained that the agency cost to cover medical shifts is increasing and posts are becoming more difficult to recruit to. BG added that it is easier to mitigate for nursing risk. The Committee queried why Psychiatry Liaison was no longer included on either risk register; BG clarified that this risk was specific to cover within the Emergency department of York Hospital. She confirmed that the Psychiatric Liaison Consultant has agreed to extend the service in the York Emergency Department so this is no longer a risk.		
4	**CQC action plan**	The Committee reviewed the action plan following the CQC visit in March 2015. AP explained that the improvements on the action plan had been disseminated from Board to the Committees that would be able to provide assurance on each issue through their pre-existing agenda items. The Committee requested that the report be presented to Board in its existing format and a named executive be added to each action for accountability. The Committee discussed each action and requested some changes to the committee allocations. AP agreed to update the action plan.		

	Agenda Item	Comments	Assurance	Attention to Board
	Safety			
5	Nurse Staffing CRR Ref: CN2	BG explained that Nurse Staffing is a key objective of the Nursing and Midwifery Strategy and has proved to be the greatest challenge. Focussed work has been taking place over the last 12 – 18 months and the Trust is now in an improved position. A large local cohort of newly qualified nurses commenced in November and recruited Spanish and Italian nurses are now working within the Trust as Health Care Assistants until their nursing registration numbers come through. The Trust continues to actively recruit EU nurses with 25 further interviews scheduled to take place. If these appointments are successful 55 EU Nurses will have been recruited in total, the original business case was to recruit 60 EU nurses. Collaborations have been set up with York St Johns University and this will expand to Coventry University's new Scarborough Campus, Teeside and Hull. More nurses are joining the internal bank. Additional incentives for bank staff by way of weekly pay and enhanced rates have been used and a lead nurse is in place to support these individuals. It is hoped that these measures will improve both the financial burden from agency payments and patient safety. BG explained that the next steps might be to expand EU recruitment and possibly move to international recruitment. All of the above actions are designed to bring ward vacancy rates down to a more acceptable level. The Committee agreed that the new Nursing dashboards were clear, easy to follow and that risks were easily identifiable. It was proposed that these replace the EWTT report and safer staffing report and are incorporated into the	The Committee were assured by the activity and focus on this area which is reflected in the development of the nursing dashboard and early signs of a reduction in vacancy rates from peak levels.	BG to update Board

	Agenda Item	Comments	Assurance	Attention to Board
		monthly information pack – in line with the general shift away from additional committee reports. BG confirmed that the dashboards will be used at PMMs. The Committee queried the changes in skill mix on some of the wards. BG confirmed that this is still taking place. The Safer Staffing tool is based on the latest adjusted planned staffing on wards.		
6	Medical Staffing CRR Ref: MD2	JT confirmed that the data around Medical Staffing is not available as each department has a different staffing model dependant on the type of work undertaken. Consultants are recruited through a business case. JT highlighted that the biggest areas of risk from a medical staffing perspective are the Emergency Departments. Consultant recruitment attempts have failed and the availability of middle grades is equally poor. Both services are relying on locum doctors which affect both risk and quality. Proposals for new staffing models will be put forward for York and Scarborough. The role of the Associate Specialist will be enhanced and a case is being made to run the Advanced Clinical Practitioner programme again. Doctors Strike JT confirmed that some elective activity was cancelled for the doctor's strike but that this was limited largely to outpatient appointments. Each directorate has plans to mitigate patient risk in the event of further strike action – with greater reliance on the consultant body to fill in, the risk to patient safety is not expected to be significant.	The Committee agreed that the assurance for this work may be picked up by the Workforce Strategy Committee.	JT to take to Board

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee discussed the complexities of measuring Medical Staff vacancies and agreed that this needed additional focus and that the MD will give some thought to how to provide further information and assurance on this important issue.		
7	Deteriorating Patient CRR Ref: MD4, MD6	The Committee queried the work being undertaken around 24hour care, senior review on admission and regular senior review. JT explained that the Organisation will come under pressure regarding seeing patients in a timely manner and work is planned to take place around staffing levels and culture. JT advised the Committee that Juliet Walters has put together a Task and Finish Group who will focus on 2 Keogh Standards; senior review within 14 hours of admission and a daily review thereafter. The Group will put a new Medical Rota proposal together for the York site, which will go out for discussion. Shifts patterns, hours of work and the Consultant contracts will be taken in to account. The Committee queried the focus on York site given the greater challenge at Scarborough and the immediate risk this poses to patient safety. The Committee agreed that this topic will continue to be an area of focus.		JT/JW to take to Board.
8	Incidents of harm CRR Ref: MD4, MD6, CN2	JT led the Committee through the SI reports containing in the Medical Directors report. The Committee queried if learning from these incidents is shared throughout the organisation. JT confirmed that this work is on-going and an appointment has been made to lead Patient Safety and the		

	Agenda Item	Comments	Assurance	Attention to Board
		SI process. Falls - The Committee raised concerns over the increase of falls resulting in severe harm in November BG will explore. Pressure Ulcers – The committee queried the recent increased prevalence of Pressure ulcers on all sites, but particularly within Community hospitals. BG confirmed that progress is being made in decreasing the severity of incidents. Themes and trends are being closely monitored. BG explained to the Committee that there is still work to do with staff around validation of incidents and not reporting the same incident more than once. This is reflected in the data.		
9	Infection Prevention CRR Ref: CN7,CN8	The Committee noted the inclusion of the IPC quarterly report. BG confirmed that there have been 52 reported cases of CDIFF which exceeds the trajectory of 48. 12 of these cases are awaiting a Post Infection Review. 9 cases have been classified as “no breach in care” and will not be included in the year end total for financial penalty payments. An MRSA Bacteraemia case has been reported in Selby on a deteriorating patient who had previous MRSA and had not been decolonised. The post infection review is due to take place. BG will update at Board. The Terms of Reference and Governance Structure of the IPC Group have been agreed and the new Executive led Group will commence imminently. A work plan has been devised following the external review and is RAG rated for	The committee took considerable assurance from the increasingly robust approach around IPC – particularly the formulation of plans to mitigate for a lack of isolation facilities within the Trust.	BG to take to Board.

	Agenda Item	Comments	Assurance	Attention to Board
		key risks. A deep clean programme will be put in place using Wards 24, Graham and Haldane to decant patients. The Group will also be challenged to look in to if side rooms are being used appropriately. 10 wards were affected by norovirus at the start of November. The virus was contained quickly and managed well.		
	Safety Walkrounds	NEDs queried a hiatus in the safety walkround schedule.		
9.	**Effective**			
10	Clinical Best Practice CRR Ref: MD2, CN2	The Committee focused on the A&E Urgent Care streaming paper. JT confirmed that the model suggested by the CQC has now been changed as it resulted in greater delays for patients. The Committee queried this reversal of a CQC requested action. JT stated that the new initiative is being led by the Emergency Department, who believe that this is a safe option and has resulted in some improvement in the 4hour target. The ECIST team have also been consulted. Sign up to Safety The Committee discussed the Sepsis CQUIN. JT explained that the screening element of the CQUIN is on target but the administration of antibiotics in an hour may not be achieved. The Committee discussed how performance could be improved in quarter 4. JT advised that a cost analysis of placing a Sepsis 'champion' nurse in the Emergency Department is currently taking place. The Committee were pleased to hear that a date has been set for the next Trust Patient Safety Conference in 2016.		JT to take to Board

	Agenda Item	Comments	Assurance	Attention to Board
		The Committee raised concern that the compliance with dementia screening on the Scarborough site has gone down and this has been a focus of the Governors and many of the Non-Executive Directors. JT advised that the drop has been noted and weekly performance meeting are taking place. JT confirmed that specific CQC concerns are being progressed in Pain Management, Dietetics, Critical Care and Outreach. The issue of harmonisation of clinical protocols and procedures across the Trust was to be addressed through the recent appointment of 5 part-time clinical fellows with quality and service improvement projects. The committee queried if this issue was worthy of escalation to the CRR of the MD.	The Board will be receiving further assurance on these specific CQC actions in March via a quarterly update report from the Deputy Director of Healthcare Governance.	
11	Mortality CRR Ref: MD2, MD4	JT advised that the Hospital SHMI is embargoed until Board, however confirmed that both acute sites were within the allowed range. Diane Palmer is producing a paper around avoidable deaths, the new D of H mortality measure, which will come to the Committee once complete. The Committee noted the contents of the Mortality report and felt that whilst it provided assurance that 70% of hospital deaths were now subject to a mortality review it did not provide any actions or clarify areas of concern. JT advised that the process is currently done manually and a plan to add this to CPD is being discussed. The electronic pro-forma should increase the compliance with review from	The Committee received the first edition of the Trust Mortality Review Report – for Q1 2015/16, a product of the Patient Safety Strategy	JT to update Board on latest SHMI

	Agenda Item	Comments	Assurance	Attention to Board
		70%. Maternity Mortality The Committee questioned the NHS mandate to reduce still births and maternal deaths and queried some warning signs on the York site dashboard including why no SI's had been reported. BG explained that Maternity have their own robust process in place and still births have reduced by 50% in the last 12 months. The data from 2013 shows the Trust as an outlier for still births but recently are well within the national data range. The Committee look forward to reviewing the maternity report at next months' meeting and were pleased to hear that the strong structural approach at Scarborough will be rolled out in York.		
12	Medication Governance CRR Ref: MD1	The Committee noted that Electronic Prescribing is due to be piloted next month and requested an update from JT come to next months' meeting.		
13	Acute Flow CRR Ref: MD6	JT and BG advised the Committee of the multiple management changes throughout the organisation. A new Band 7 patient flow manager is in place and Directorate Managers and Executives are now dealing with operational issues out of hours. Discharge Liaison Officers have been implemented on the York site to aid the discharging of patients and free up beds in the downstream wards. The new Ambulatory care unit is open with a pathway in place. Elderly Medicine Consultants are visiting patients in the Emergency Department to avoid admissions where possible.	The committee took assurance from the considerable focus being brought to this issue of both safety and performance.	
	Caring			

	Agenda Item	Comments	Assurance	Attention to Board
14	Patient Experience	The Committee raised concerns that the 1.2% response rate for the Friends and Family test would not produce meaningful data. BG advised that the Patient Experience Steering Group will be meeting this week and will put a recommendation together. Hester is exploring all other avenues of patient feedback. BG agreed to update the Committee at the next meeting.	The committee took assurance from the increased attention being given to all aspects of patient feedback via the new PE team.	BG to take to Board
	Additional agenda items			
15	Effective Discharge from Hospital	The Committee noted the inclusion of the discharge letters.		
16	Quality Report for 2016/17 update	The Committee discussed the Quality Priorities for 2016/17. BG explained that discussions with the key stakeholders would inform the priorities and the priorities would then inform the CQUINS. AP advised the Group that there is no guidance available and the report will be based on the lay out from last year. The Committee agreed that all priorities need to be measurable. The Committee agreed to send any suggestions to BG and AP via email.		
	Review of the approach to the agenda for the Q&S Committee	The Committee agreed that meetings and the reports provided would need to be reordered and reorganised for the new approach to the agenda (based on CQC standards) to work. JA to liaise with BG and JT ahead of the next meeting to agree a workable approach. As part of the agenda refresh the Committee will ensure the Corporate risks of the Chief Nurse and Medical Director will be reviewed for possible amendments each month. No changes were identified this month.		

Patient Safety & Quality Report

January 2016

Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Patient Experience

There has been a further decrease in the number of PALS contacts; 450 in December at York, the lowest since Q1. Data currently unavailable for Scarborough site.
There were 13 complaints at York and 15 at Scarborough in December; a decrease of 10 for the Trust compared to November.

The Friends & Family Test (FFT) is no longer a CQUIN for 2015/16, but forms part of the Trust's Commissioner contracts.
Response rates to the Inpatient FFT have dropped in Q3 compared to Q2; the Trust saw a decrease from 21.4% (Q2) to 16.7% (Q3).
In comparison, response rates for the ED FFT have seen an improvement; the Trust achieved 7.8% in Q2 and 8.3% in Q3.
Response rates to the Community FFT reached the lowest levels in December achieving 0.7%, however 100% of respondents would recommend the Trust. 1.2% response rate achieved in Q3.
Response rates to the Maternity FFT in December remain low in comparison to previous months; this combined with low responses in November has affected the Q3 figures significantly. For example, the response rate to the Antenatal stage dropped from 27.3% in Q2 to 12.2% in Q3. Despite this, the 90% target for patients to recommend the Trust was achieved across all 4 stages (Antenatal, Labour, Postnatal and Postnatal Community.

Measures of Harm

12 Serious Incidents (SIs) were declared in December (5 x York, 4 x Scarborough and 3 x Community). 5 of the SIs were attributed to 'clinical incident', 4 were attributed to 'slips, trips and falls' and 3 to pressure ulcers.

There were no 'Never Events' reported.

Infection Prevention

7 cases of Cdiff were identified in December, (5 at York, 2 at Scarborough). The YTD total is now 50 against an annual maximum of 48, therefore above trajectory.

No new cases of MRSA were identified in December. There has been a total of 6 MRSA since April 2015, 5 in Scarborough and 1 at York.

2 patients were identified with MSSA taking this above the 2015/16 trajectory, YTD total 30.

There were also 8 cases of E-Coli identified in December taking the YTD total to 63.

Quality and Safety - Miscellaneous

Stroke
In November 89.0% of patients spent 90% of their stay on a stroke unit, this is against the local target of 80%. The Trust achieved the Target for the percentage of patients scanned within 24 hours of hospital arrival (90.4%) and for those patients who experienced a TIA were assessed and treated within 24 hours (76.9%). 77.8% of patients requiring an urgent scan were scanned within 1 hour, target achieved.

Cancelled Operations
The number of operations cancelled within 48 hours of the TCI due to lack of beds decreased from 66 in November to 39 in December; this is within the monthly maximum of 65. The YTD total for the Trust is currently 427.

Cancelled Clinics/Outpatient Appointments
The number of cancelled clinics with less than 14 days notice increase slightly compared to November (141) to 143; 100 at York and 43 at Scarborough. There was a notable decrease in the number of cancelled appointments from 852 in November to 764 in December, however this still exceeds the monthly maximum of 745 and will result in General Condition 9 which is initially a Performance Notice.

Ward Transfers between 10pm and 6am
The number of inappropriate ward transfers decreased to 91 in December (56 in York and 35 in Scarborough) and is within the monthly maximum threshold of 100.

Care of the Deteriorating Patient

The Trust saw a slight increase in the proportion of Medicine and Elderly patients receiving a senior review within 12 hours of admission; 72.6% in November, 72.8% in December. York achieved 84.1% and Scarborough 56.0%.

77.5% of Medicine and Elderly patients were seen by a doctor within 4 hours of admission, across both sites. The Trust achieved 82.0% for Q3; an increaase on Q2 (80.1%).

The Trust has an internal target of 90% of routine observations being undertaken within 1 hour of the prescribed time. Currently achieving 87.3% for December and 86.9% for Q3; a slight decrease on Q2 (87.4%).

Drug Administration

There were 9 insulin errors reported in December; 4 at York, 3 at Scarborough and 2 Community. A total of 33 were reported in Q3.

20 Prescribing errors were reported in December; 12 at York, 5 at Scarborough and 3 Community. A total of 59 were reported in Q3.

Mortality

The Apr 14 - Mar 15 SHMI remained static at 101 , with York seeing a 1 point reduction and Scarborough seeing a 1 point increase.

RAMI has seen a slight improvement although remains above the Peer.

The number of deaths in December was in line with previous months; 189 inpatient deaths and 21 ED deaths across the Trust.

CQUINS update

Quarter 2 2015/16 CQUINS; all schemes are RAG rated as green.

Litigation

Indicator	Site	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Clinical Claims Settled	York	2	2	4	5	1	2	3	3	3
	Scarborough	1	1	0	3	5	2	2	7	1

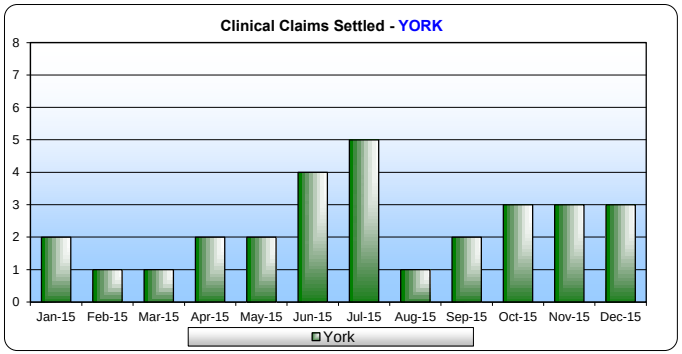
In December, 4 clinical claims were settled; 3 attributed to York & 1 attributed to Scarborough.

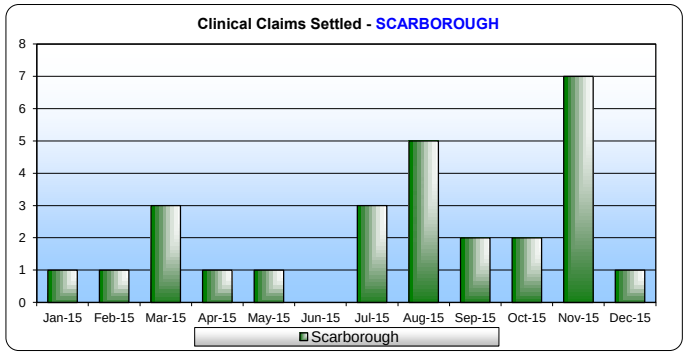
7 clinical negligence claims were received for York site and 8 were received for Scarborough. York had 5 withdrawn/closed claims and Scarborough had 0.

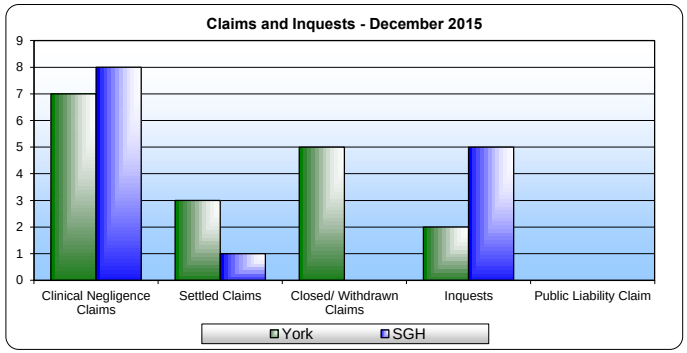
There were 7 Coroner's Inquests heard (2 York & 5 Scarborough).

Litigation

Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Clinical Claims Settled source: Risk and Legal	York	2	1	1	2	2	4	5	1	2	3	3	3
	Scarborough	1	1	3	1	1	0	3	5	2	2	7	1







Themes for Clinical Claims Settled 01 Jan 2012 to 09 Dec 2015

Incident type	York Number	Damages	Sboro Number	Damages
Anaesthetic error	1	£27,500	0	£0
Delay in treatment	2	£1,176,000	8	£4,886,655
Failure to act on CTG	1	£13,500	0	£0
Failure to adequately interpret radiology	7	£53,150	6	£76,463
Failure to diagnose/delay in diagnosis	2	£4,500	1	£45,000
Failure to investigate further	11	£1,198,619	11	£1,211,971
Failure to refer to other speciality	4	£2,047,500	0	£0
Failure to retain body part	1	£25,000	0	£0
Inadequate consent	2	£12,500	3	£79,000
Inadequate examination	4	£147,500	3	£149,847
Inadequate interpretation of cervical smear	1	£37,500	0	£0
Inadequate nursing care	6	£67,000	6	£35,500
Inadequate procedure	2	£10,130	2	£48,750
Inadequate surgery	9	£1,103,750	9	£593,066
Inappropriate discharge	1	£315,000	3	£18,000
Intraoperative burn	3	£25,000	1	£5,000
Lack of appropriate treatment	2	£45,672	6	£407,196
Lack of risk assessment/action in relation to fall	2	£24,250	0	£0
Lack of risk assessment/action in relation to pressure ulcer	1	£7,000	1	£50,000
Maintenance of equipment	1	£5,000	0	£0
Not known	0	£0	3	£60,000
Prescribing error	2	£22,500	0	£0
Lack of monitoring	1	£150,000	1	£80,000
Results not acted upon	6	£47,500	2	£352,000

Patient Experience

Complaints
There were a total of 28 complaints in December; 13 at York and 15 at Scarborough.

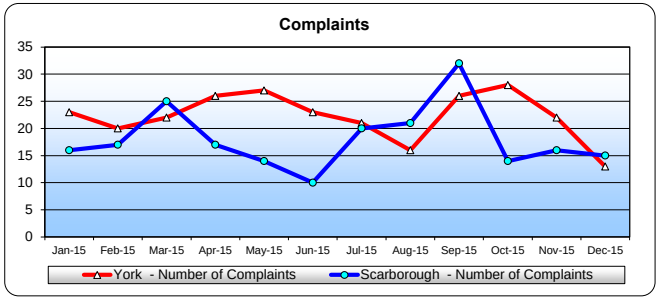
PALS contacts
There were 450 PALS enquiries at York Hospital in December, Scarborough figures are not currently available.

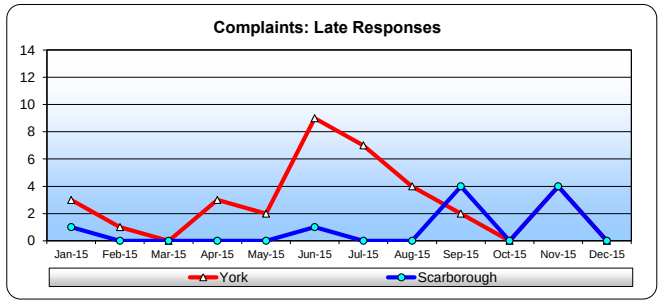
New Ombudsman Cases
There was 1 New Ombusman case in December at York.

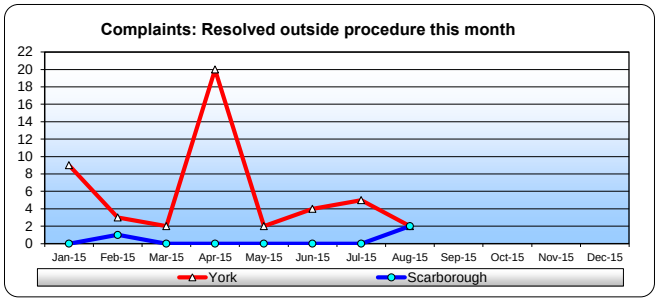
Complaints – Late Responses
Currently unavailable for December due to reporting limitations.

Patient Experience

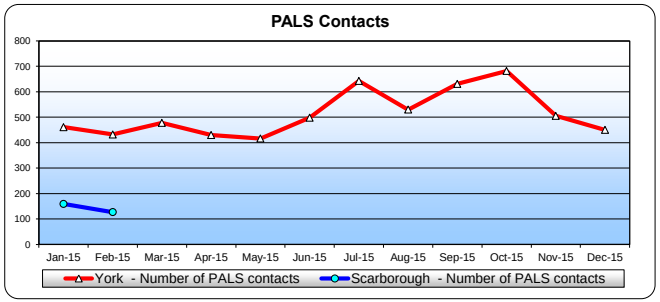
Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Complaints	York	23	20	22	26	27	23	21	16	26	28	22	13
	Sboro	16	17	25	17	14	10	20	21	32	14	16	15
PALS contacts	York	461	432	478	430	416	498	643	530	631	682	505	450
	Sboro	159	127	0	0	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
New Ombudsman Cases	York	2	4	7	2	2	1	0	2	1	0	2	1
	Sboro	1	0	0	0	2	0	1	1	0	0	0	0
Complaints - Late Responses	York	3	1	0	3	2	9	7	4	2	0	4	Not available
	Sboro	1	0	0	0	0	1	0	0	4	0	4	Not available
Complaints - Resolved outside procedure this month	York	9	3	2	20	2	4	5	2	0	0	0	Not Available
	Sboro	0	1	0	0	0	0	0	2	0	0	0	Not Available

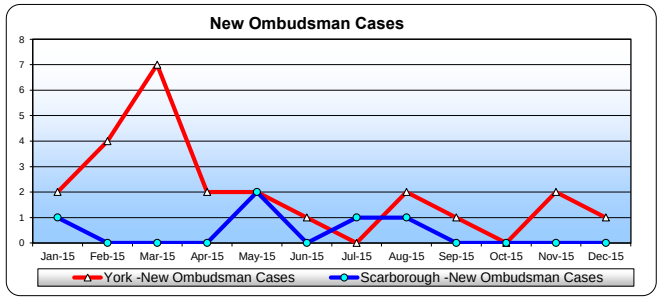






Complaints: Resolved outside of procedure - this category is longer used due to a change in reporting.





Patient Experience

December 2015

Complaints by directorate/division (Datix)	York	Sboro	Brid	Comm.	Total
Allied Health Professional	0	0	1	0	1
Child Health	0	1	0	0	1
Community Services	0	0	0	0	0
Elderly Medicine	1	1	1	0	3
Emergency Medicine	4	2	0	0	6
Estates and Facilities	0	0	0	0	0
General Surgery & Urology	3	4	0	0	7
Head and Neck	1	1	0	0	2
Laboratory Medicine	0	1	0	0	1
Medicine (General & acute)	1	1	0	0	2
Obstetrics and Gynaecology	2	0	0	0	2
Operations	0	0	0	0	0
Orthopaedics and Trauma	1	1	0	0	2
Pharmacy	0	0	0	0	0
Radiology	0	0	0	0	0
Specialist Medicine	0	1	0	0	1
Theatres Anaesthetics and Critical Care	0	0	0	0	0
Total	**13**	**13**	**2**	**0**	**28**

Complaints by subject (Datix)	Total
Access to treatment or Drugs	1
Admissions, discharge and transfer arrangements	3
All aspects of clinical treatment	24
Appointments	1
Commissioning	0
Communication/information to patients (written and oral)	9
End of life	0
Mortuary	0
Patient Care	11
Patient Concerns	0
Prescribing	2
Staff Numbers	1
Privacy, Dignity and Respect	0
Values and Behaviours (staff)	3
Waiting Times	1
Total	**56**

Due to new reporting the number of complaints by subject is greater than the total number of complaints because each subject within the complaint can be identified as opposed to just the one deemed to be the 'primary'.

PALS Contacts by Subject	All Sites
Action Plan	9
Admissions, discharge, transfer arrangements	11
Aids / appliances / equipment	2
Appointments, delay/cancellation (inpatient)	14
Appointments, delay/cancellation (outpatient)	40
Staff attitude	13
Any aspect of clinical care/treatment	53
Communication issues	40
Compliment / thanks	44
Alleged discrimination (eg racial, gender, age)	2
Environment / premises / estates	3
Failure to follow agreed procedure (including consent)	4
Hotel services (including cleanliness, food)	3
Requests for information and advice	171
Medication	3
Other	3
Car parking	2
Privacy and dignity	1
Property and expenses	14
Personal records / Medical records	9
Safeguarding issues	1
Support (eg benefits, social care, vol agencies)	4
Patient transport	4
Totals:	**450**

Friends and Family

Indicator		Target	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Inpatients – York	York IP Response Rate	Monitoring Only	32.9%	38.4%	45.4%	16.0%	17.4%	18.3%	20.6%	17.4%	18.9%	18.6%	13.8%	11.9%
Inpatients – Scarborough	Scarborough IP Response Rate		41.2%	52.4%	55.8%	16.4%	16.5%	15.3%	21.3%	18.2%	18.0%	18.2%	17.5%	15.1%
Inpatients - Bridlington	Bridlington IP Response Rate		77.0%	90.2%	69.5%	56.0%	47.5%	46.0%	51.6%	69.0%	62.0%	50.2%	24.6%	32.3%
Inpatients – Combined	**Trust IP Response Rate**		**37.7%**	**44.7%**	**49.4%**	**18.6%**	**19.2%**	**19.4%**	**22.6%**	**20.3%**	**21.2%**	**20.3%**	**15.6%**	**14.0%**
ED – York	York ED Response Rate	Monitoring Only	14.8%	14.0%	19.2%	8.3%	8.6%	8.3%	10.0%	9.2%	7.4%	9.6%	10.0%	10.7%
ED - Scarborough	Scarborough ED Response Rate		28.2%	36.8%	29.8%	6.7%	7.3%	6.1%	6.3%	5.8%	4.9%	3.0%	3.6%	7.0%
ED – Combined	**Trust ED Response Rate**		**19.3%**	**21.6%**	**22.8%**	**7.8%**	**8.2%**	**7.6%**	**8.8%**	**8.0%**	**6.5%**	**7.4%**	**7.9%**	**9.9%**
Maternity – Antenatal		None	30.6%	27.6%	36.0%	26.4%	27.5%	31.7%	29.1%	23.7%	29.3%	22.9%	1.9%	9.8%
Maternity – Labour and Birth			19.9%	27.9%	38.5%	31.0%	25.6%	26.7%	28.5%	23.3%	36.2%	26.1%	3.9%	25.1%
Maternity – Post Natal			27.9%	31.9%	32.6%	30.4%	29.0%	29.3%	27.3%	25.5%	40.5%	27.3%	3.8%	0.0%
Maternity – Community			21.3%	14.6%	23.1%	24.3%	18.4%	20.3%	18.7%	19.8%	20.9%	26.2%	2.8%	5.1%

The Friends & Family Test is no longer a CQUIN for 2015/16, but will be monitored under Schedule 4 of the Trust's commissioner contracts.

From April 2015 day cases and patients under 16 have been included in the Inpatient performance in line with NHS England requirements. This has significantly increased the numbers of eligible patients so had a significant effect on the response rates. NHS England guidance states that response rates are not directly comparable between 2014-15 and 2015-16.

The Trust quality standard for Friends and Family Test Performance is to achieve 90% of responses either extremely likely or likely to recommend.

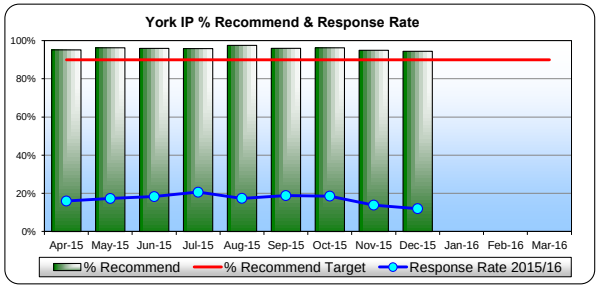
The focus for the Trust is to gain and understand patient feedback and encourage Directorates to use that feedback to drive improvements. Each ward displays a 'Knowing How We're Doing' board which is a giant poster sharing FFT data and comments from that particular ward, along with news and improvements on that ward. By showing patients that we listen to their views and try to make improvements, we hope to encourage more responses and suggestions. The next step for 'Knowing How We're Doing' boards is to roll them out to Outpatient areas across the Trust.

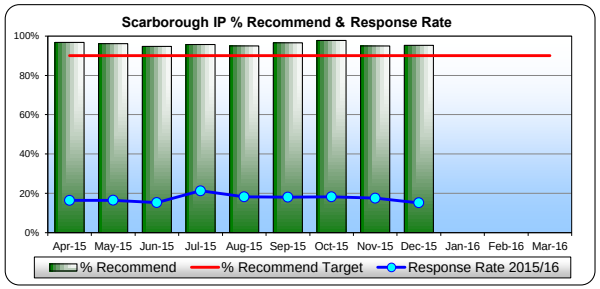
Friends & Family: Inpatients & ED

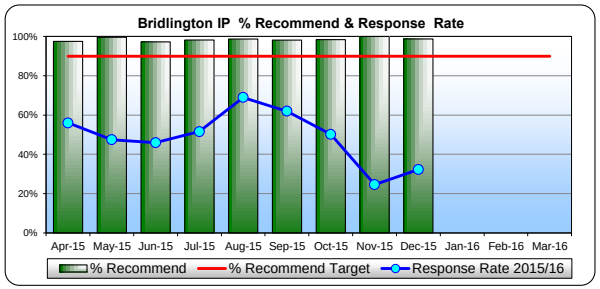
The Friends & Family Test (FFT) has now been rolled out across the Trust, including all Inpatients and Daycases, (previously daycase s and patients <16 were excluded) those attending ED, Community patients and women accessing maternity services being asked the question; "would you recommend this ward/ED/antenatal/labour and postnatal service to your family & friends?". The Friends and Family Test is no longer a CQUIN Target for 2015/16, however the focus for the Trust remains to ensure that the qualitative feedback gained through FFT is used effectively to inform patients of what the Trust is doing to improve their experience of our Services.

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct-15	Nov-15	Dec-15
Trust Inpatient Response Rate (including daycases)	None - Monitoring Only	none	43.9%	19.1%	21.4%	16.7%	20.3%	15.6%	14.0%
York Inpatient Response Rate (including daycases)	None - Monitoring Only	none	39.0%	17.3%	19.0%	14.8%	18.6%	13.8%	11.9%
York Inpatient % Recommend	None - Monitoring Only	none					96.3%	95.0%	94.4%
York Inpatient % Not Recommend	None - Monitoring Only	none					1.1%	1.6%	2.6%
Scarborough Inpatient Response Rate (including daycases)	None - Monitoring Only	none	49.4%	16.0%	19.2%	17.0%	18.2%	17.5%	15.1%
Scarborough Inpatient % Recommend	None - Monitoring Only	none					97.8%	95.0%	95.3%
Scarborough Inpatient % Not Recommend	None - Monitoring Only	none					0.4%	1.0%	1.1%
Bridlington Inpatient Response Rate (including daycases)	None - Monitoring Only	none	78.1%	49.4%	60.3%	35.5%	50.2%	24.6%	32.3%
Bridlington Inpatient % Recommend	None - Monitoring Only	none					98.4%	100.0%	98.7%
Bridlington Inpatient % Not Recommend	None - Monitoring Only	none					0.8%	0.0%	0.0%

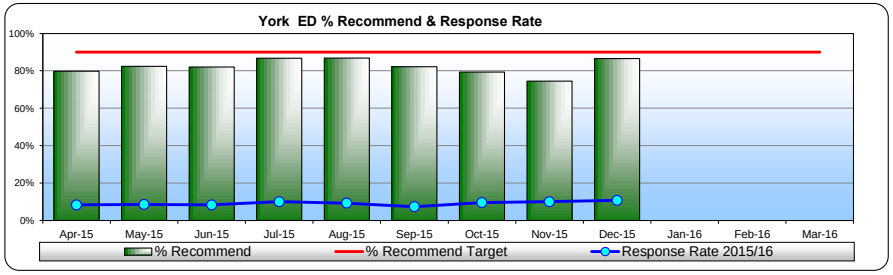
Daycase patients and young people (<16 years) included in FFT April 2015

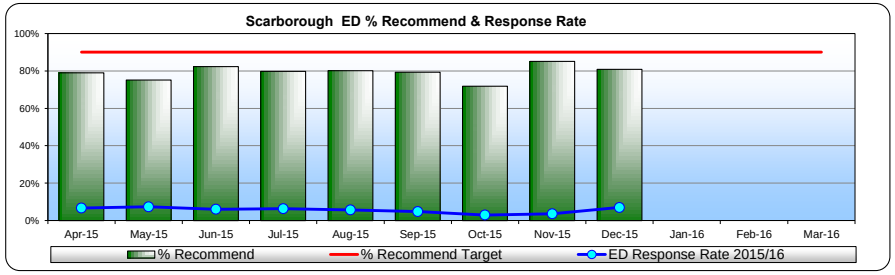






Indicator	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct-15	Nov-15	Dec-15
Trust Emergency Department Response Rate	None - Monitoring Only	none	21.3%	7.8%	7.8%	8.3%	7.4%	7.9%	9.9%
York Emergency Department Response Rate	None - Monitoring Only	none	16.1%	8.4%	8.9%	10.1%	9.6%	10.0%	10.7%
York Emergency Department % Recommend	None - Monitoring Only	none					79.4%	74.5%	86.6%
York Emergency Department % Not Recommend	None - Monitoring Only	none					12.8%	18.3%	7.9%
Scarborough Emergency Department Response Rate	None - Monitoring Only	none	31.4%	6.7%	5.7%	4.1%	3.0%	3.6%	7.0%
Scarborough Emergency Department % Recommend	None - Monitoring Only	none					71.8%	85.1%	80.9%
Scarborough Emergency Department % Not Recommend	None - Monitoring Only	none					19.7%	9.2%	12.8%





Headline Scores

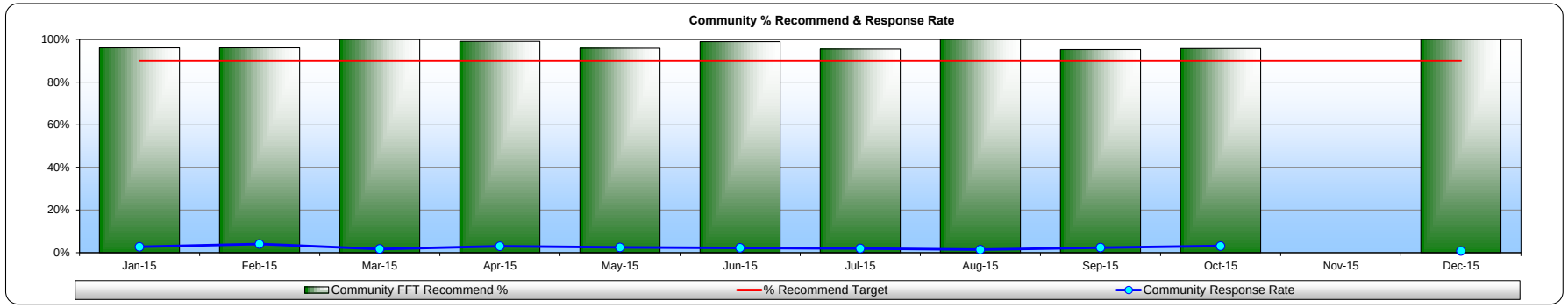
Recommend (%) $\dfrac{\text{Extremely Likely + Likely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

Not Recommend (%) $\dfrac{\text{Extremely Unlikely + Unlikely}}{\text{Extremely Likely + Likely + Neither + Unlikely + Extremely Unlikely + Don't know}} \times 100$

Friends & Family: Community

FFT Implemented in Community since January 2015

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct-15	Nov-15	Dec-15
Community Response Rate	None - Monitoring Only	none	2.8%	2.5%	1.9%	1.2%	3.1%	0.0%	0.7%
Community FFT % Recommend	None - Monitoring Only	none					95.8%	-	100.0%
Community FFT % Not Recommend	None - Monitoring Only	none					0.7%	-	0.0%

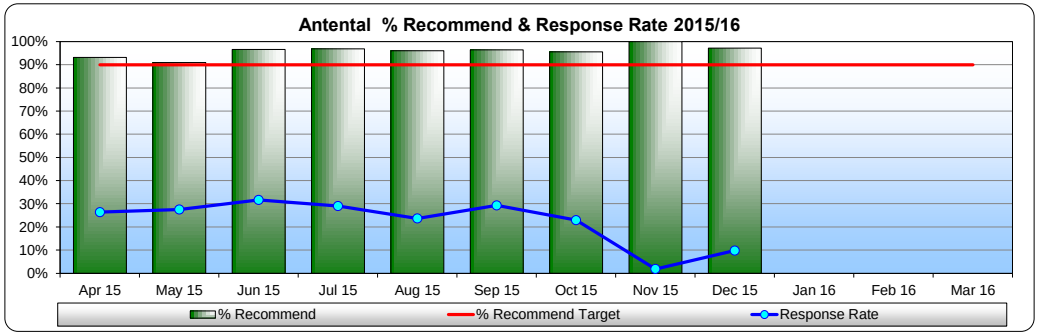


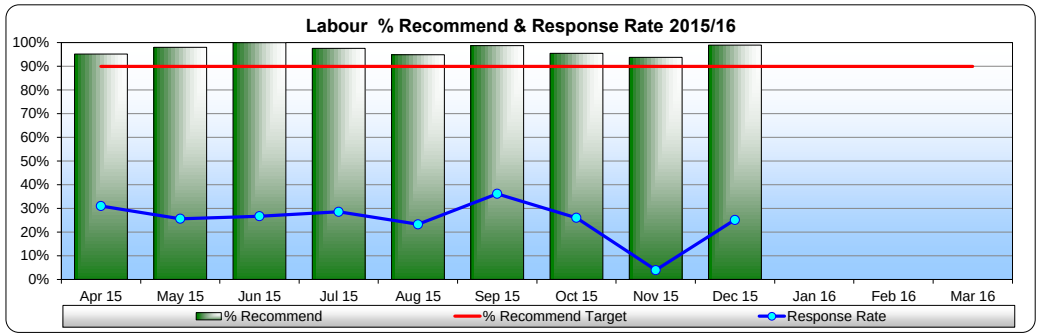
Service/Area	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct-15	Nov-15	Dec-15
Community Inpatient Services	None - Monitoring only	None	121	153	148	106	81	0	25
Community Nursing Services	None - Monitoring only	None	72	41	5	35	35	0	0
Specialist Services	None - Monitoring only	None	73	58	34	23	13	0	10
Children & Family Services	None - Monitoring only	None	2	11	8	2	2	0	0
Community Healthcare Other	None - Monitoring only	None	60	54	63	13	13	0	0

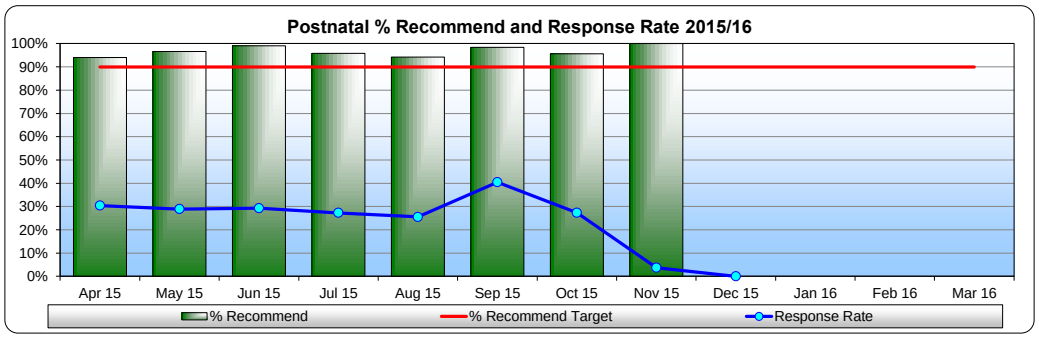
Friends & Family: Maternity

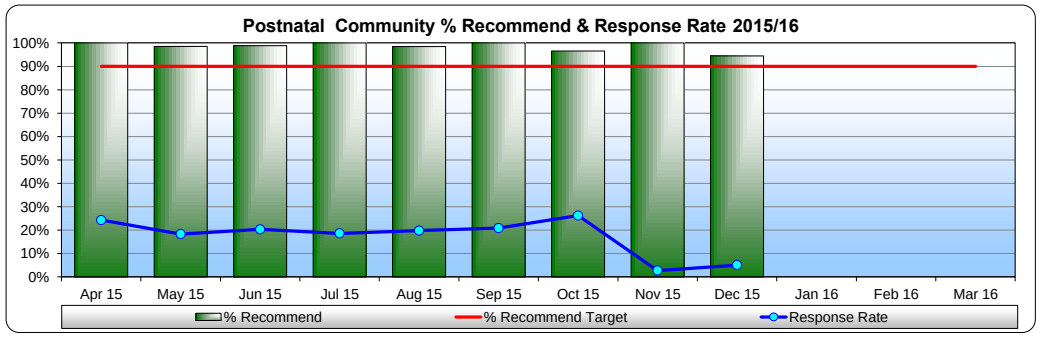
York Teaching Hospital NHS
NHS Foundation Trust

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Antenatal Response Rate	None - Monitoring only	none	31.4%	28.5%	27.3%	12.2%	22.9%	1.9%	9.8%
Antental % Recommend	None - Monitoring only	none					95.6%	100.0%	97.2%
Antental % Not Recommend	None - Monitoring only	none					1.1%	0.0%	0.0%
Labour and Birth Response Rate	None - Monitoring only	none	28.8%	27.8%	29.5%	18.3%	26.1%	3.9%	25.1%
Labour and Birth % Recommend	None - Monitoring only	none					95.5%	93.8%	99.0%
Labour and Birth % Not Recommend	None - Monitoring only	none					0.9%	0.0%	0.0%
Postnatal Response Rate	None - Monitoring only	none	30.9%	29.5%	30.7%	11.0%	27.3%	3.8%	0.0%
Postnatal % Recommend	None - Monitoring only	none					95.6%	100.0%	0.0%
Postnatal % Not Recommend	None - Monitoring only	none					1.1%	0.0%	0.0%
Postnatal Community Response Rate	None - Monitoring only	none	19.9%	21.1%	19.8%	12.2%	26.2%	2.8%	5.1%
Postnatal Community % Recommend	None - Monitoring only	none					96.6%	100.0%	94.4%
Postnatal Community % Not Recommend	None - Monitoring only	none					2.6%	0.0%	5.6%









2014/15 Performance

Indicator	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Antenatal Response Rate	41.3%	33.6%	26.0%	27.7%	33.1%	37.2%	39.8%	42.8%	32.2%	30.5%	27.6%	36.0%
Labour and Birth Response Rate	44.1%	33.3%	32.9%	19.4%	16.2%	20.4%	17.2%	39.7%	15.8%	19.9%	27.9%	38.5%
Postnatal Response Rate	47.0%	39.2%	37.5%	24.8%	20.9%	29.4%	26.5%	47.1%	19.4%	27.9%	31.9%	32.6%
Postnatal Community Response Rate	34.2%	37.2%	24.7%	21.1%	22.7%	17.2%	19.5%	18.4%	18.2%	21.3%	14.6%	23.1%

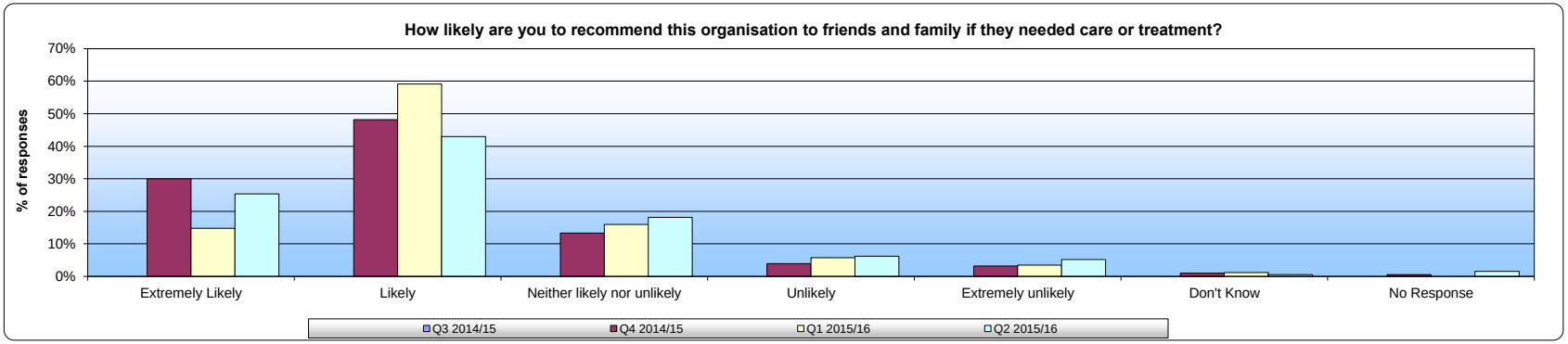
Friends and Family: Staff

York Teaching Hospital NHS
NHS Foundation Trust

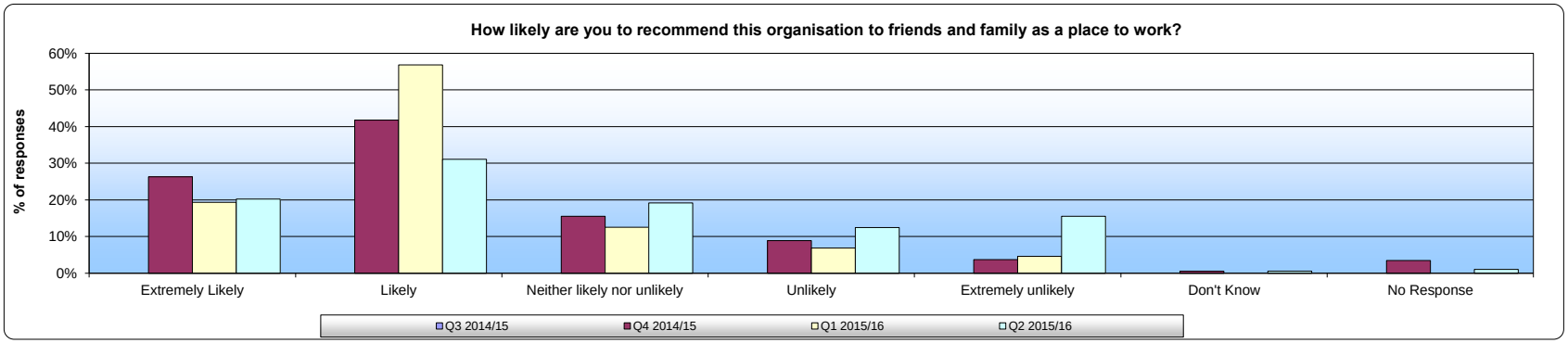
As part of the National Friends and Family CQUIN 2014/15, the Trust was required to submit evidence which demonstrates implementation of staff FFT across all Acute and Community areas.

Staff FFT data was collected and submitted quarterly for Q1, Q2 and Q4 after the end of each quarter. For Q3 (when the annual NHS staff survey is undertaken) there was no requirement to undertake Staff FFT. A proportion of staff should have the opportunity to respond to Staff FFT in each of the three quarters, with all staff having the opportunity once per year, as a minimum requirement.

Indicator	Consequence of Breach (Monthly)	Threshold	Q3 2014/15	Q4 2014/15	Q1 2015/16	Q2 2015/16
Response rate - Proportion of Trust employees who responded to the survey	None - Monitoring Only	none	Not Available	38%	49%	35%
Number of Trust employees who responded to the survey	None - Monitoring Only	none	Not Available	407	88	193



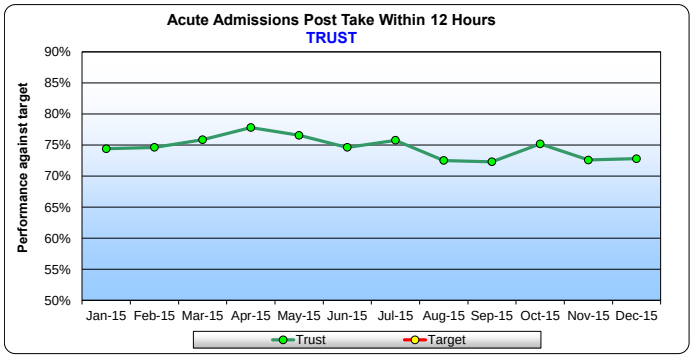
How likely are you to recommend this organisation to friends and family if they needed care or treatment?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15	30.0%	48.2%	13.3%	3.9%	3.2%	1.0%	0.5%
Q1 2015/16	14.8%	59.1%	15.9%	5.7%	3.4%	1.1%	0.0%
Q2 2015/16	25.4%	43.0%	18.1%	6.2%	5.2%	0.5%	1.6%

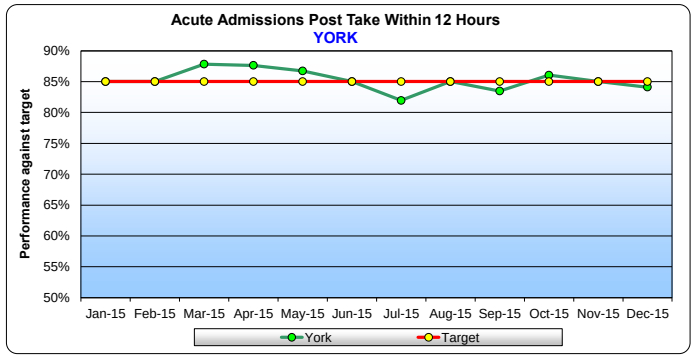


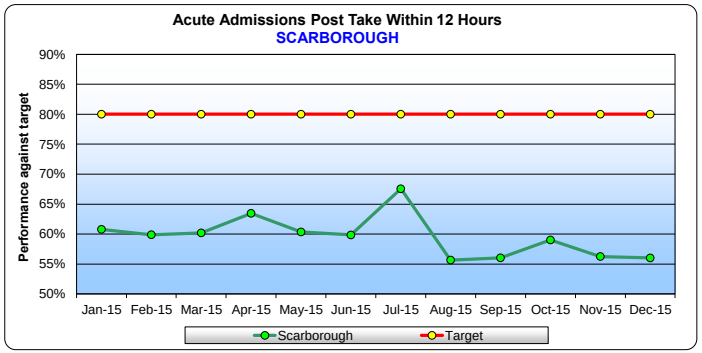
How likely are you to recommend this organisation to friends and family as a place to work?							
Quarter	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't Know	No Response
Q3 2014/15	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Q4 2014/15	26.3%	41.8%	15.5%	8.8%	3.7%	0.5%	3.4%
Q1 2015/16	19.3%	56.8%	12.5%	6.8%	4.5%	0.0%	0.0%
Q2 2015/16	20.2%	31.1%	19.2%	12.4%	15.5%	0.5%	1.0%

Quality and Safety: Care of the Deteriorating Patient

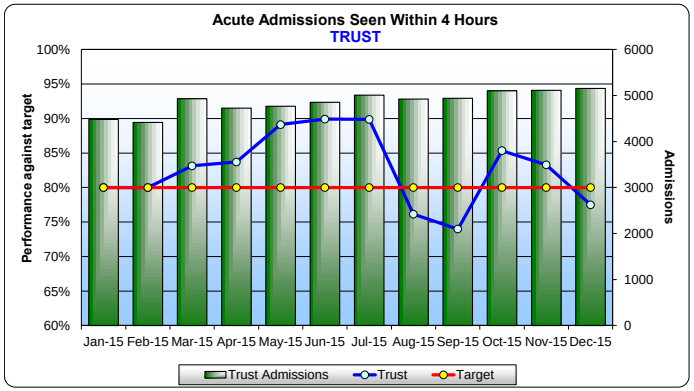
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (SCARBOROUGH)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI for 2015/16	80%	60%	61%	60%	57%	59%	56%	56%
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 12 hours of arrival (YORK)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI for 2015/16	85%	86%	86%	83%	85%	86%	85%	84%

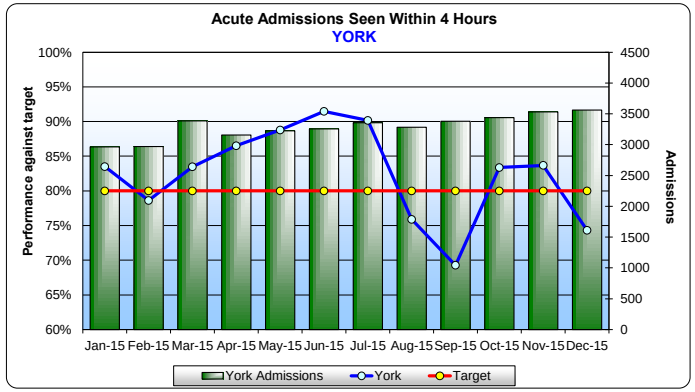


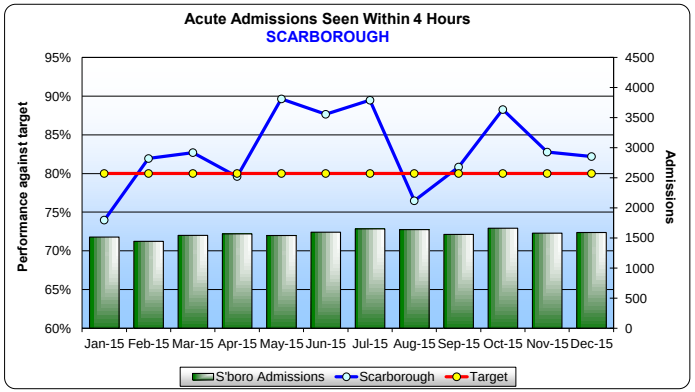




Care of the Deteriorating Patient: All acute medical, elderly medical and orthogeriatric (FNoF) admissions through AMU to be seen by a senior decision maker (registrar or nurse)	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI for 2015/16	**80% by site**	80.8%	87.5%	80.1%	82.0%	85.3%	83.3%	77.5%

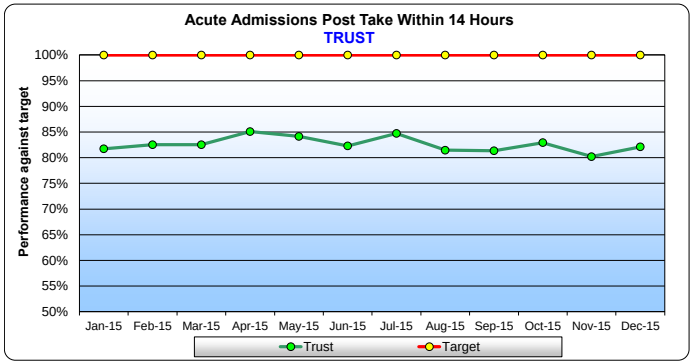


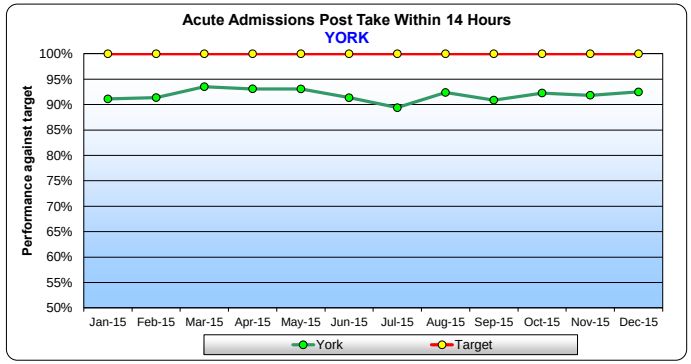


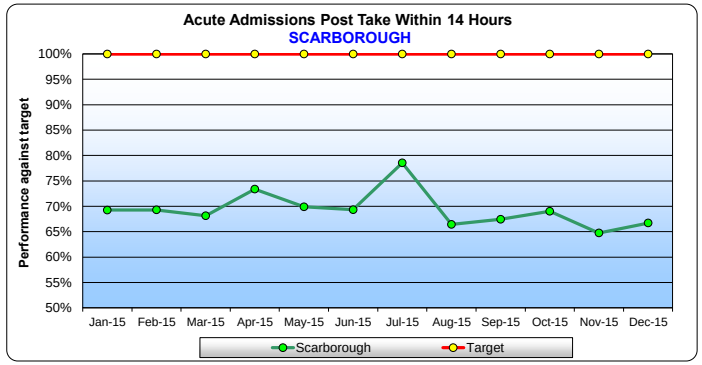


Quality and Safety: Care of the Deteriorating Patient

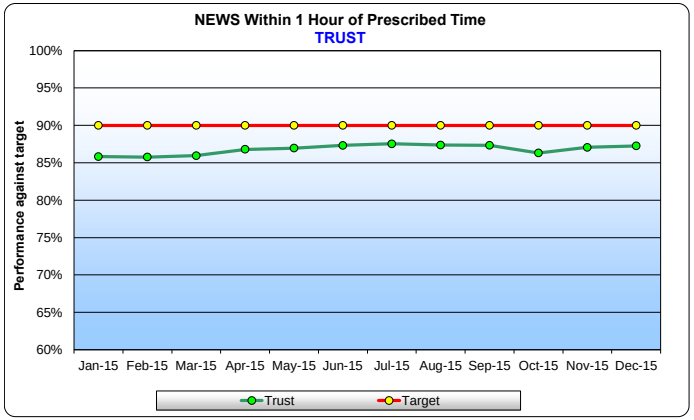
Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Care of the Deteriorating Patient on Acute Medical Assessment Units. Admissions - senior review within 14 hours of arrival - Royal College Standard - 100%	Monitoring only - Consultant post take ward round is no longer a CQUIN or contractual KPI for 2015/16		82.2%	83.9%	82.5%	81.8%	82.9%	80.2%	82.1%

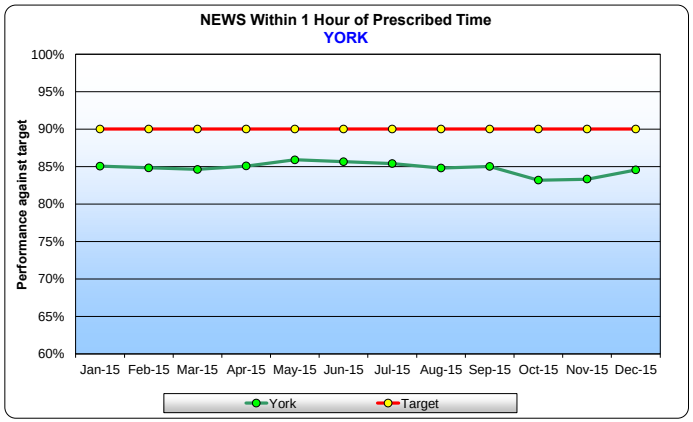


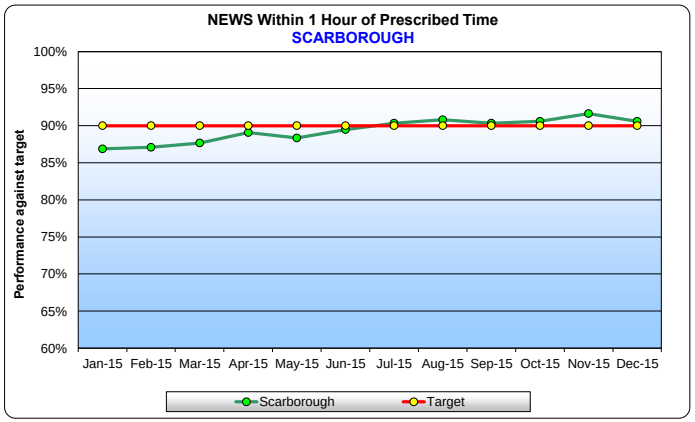




NEWS within 1 hour of prescribed time	None - Monitoring Only		85.9%	87.0%	87.4%	86.9%	86.3%	87.1%	87.3%







Measures of Harm

Serious Incidents (SIs) declared (source: Datix)
There were 12 SIs reported in December; York 5, Scarborough 4, Community 3 & Bridlington 0.
Clinical Incidents: 5; York 2, Scarborough 3.
Slips Trips & Falls: 4; York 3, Scarborough 1.
Pressure Ulcers: 3; All Community.

Patients Falls and Found on Floor (source: Datix)
Reduction in the number of patients who incur a fall while in hospital remains a priority for the Trust. During December there were 152 reports of patients falling at York Hospital, 76 patients at Scarborough and 56 patients within the Community Services. This is an increase of 50 on the number reported in November (234), and figures may increase further as more investigations are completed.

Number of Incidents Reported (source: Datix)
The total number of incidents reported in the Trust during December was 1,219; 658 incidents were reported on the York site, 406 on the Scarborough site and 155 from Community Services. This is a 5.2% increase from November (1,159).

Number of Incidents Awaiting Sign Off at Directorate Level (source: Datix)
At the time of reporting there were 1149 (increase of 260 at the end of November) incidents awaiting sign-off by the Directorate Management Teams. Risk and Legal are working with the Directorates to facilitate the timely completion of incident investigations.

Pressure Ulcers (source: Datix)
During December 20 pressure ulcers were reported to have developed on patients since admission to York Hospital, 18 pressure ulcers were reported to have developed on patients since admission to Scarborough and 23 pressure ulcers were reported as having developed on patients in our community hospitals or community care.
These figures should be considered as approximations as not all investigations have been completed.

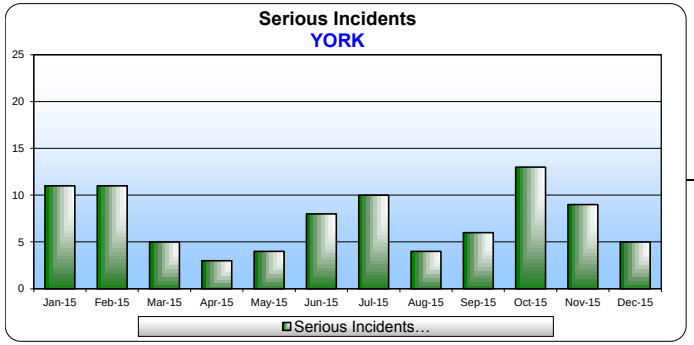
Degree of Harm: Serious/Severe or Death (source: Datix)
During December a total of 11 patient incidents were reported which resulted in serious or severe harm or death. Numbers are subject to change as levels of harm are reviewed and investigations are completed.

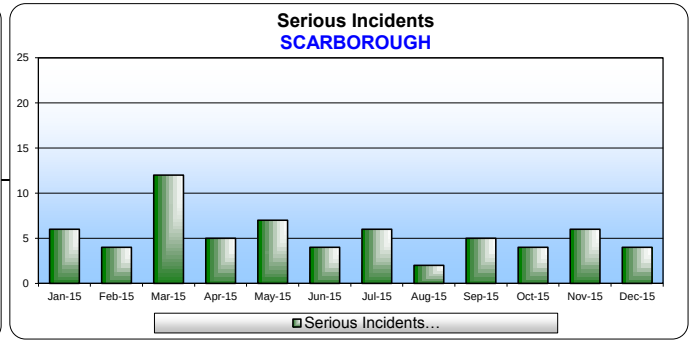
Medication Related Issues (source: Datix)
During December there was a total of 97 medication related incidents reported, although this figure may change following validation.

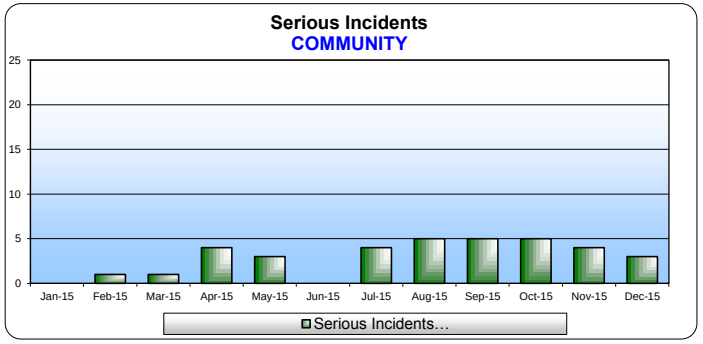
Never Events - There were zero Never Events declared in December.

Measures of Harm

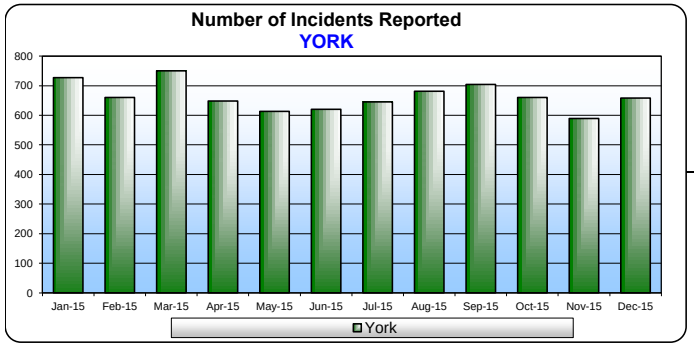
Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Serious Incidents source: Risk and Legal	York	11	11	5	3	4	8	10	4	6	13	9	5
	Scarborough	6	4	12	5	7	4	6	2	5	4	6	4
	Community	0	1	1	4	3	0	4	5	5	5	4	3
Serious Incidents Delogged source: Risk and Legal (Trust)		3	1	2	1	0	0	0	0	0	0	0	0

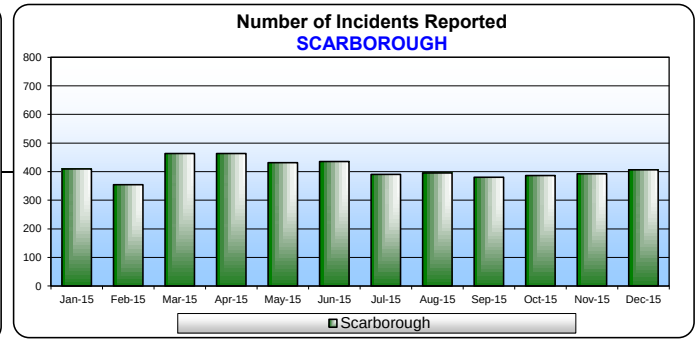


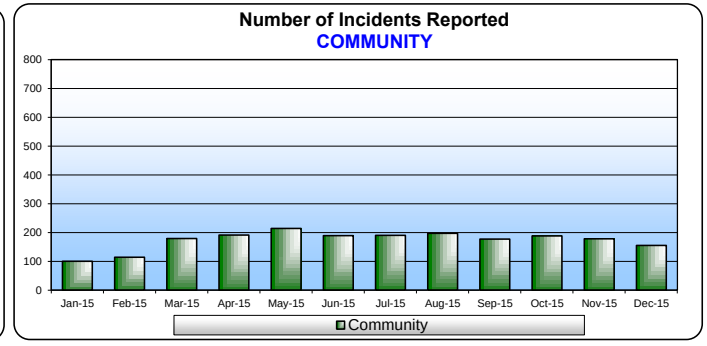




Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Number of Incidents Reported source: Risk and Legal	York	727	660	750	648	613	620	645	681	704	660	589	658
	Scarborough	409	354	463	463	431	435	390	395	380	386	392	406
	Community	100	114	179	191	214	189	190	197	177	188	178	155
Number of Incidents Awaiting sign off at Directorate level		1444	516	546	1302	863	947	1178	1229	1183	839	889	1149

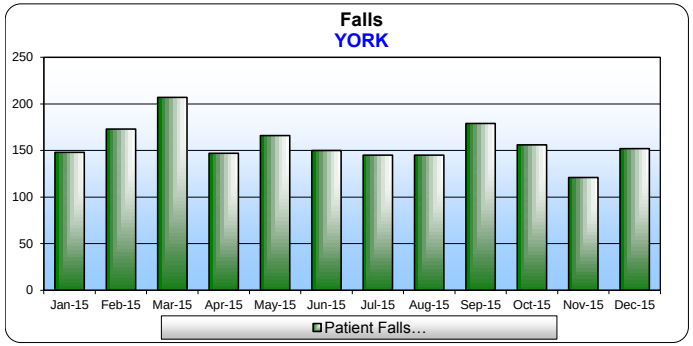


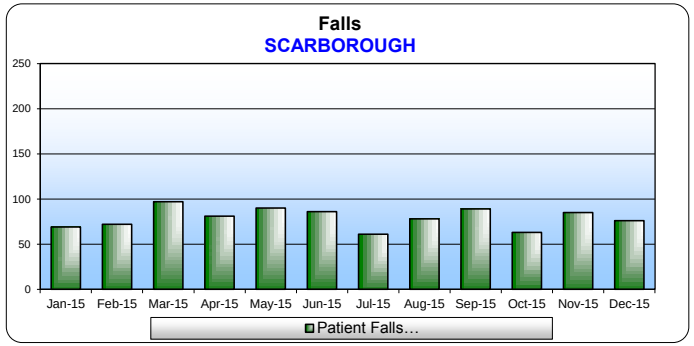


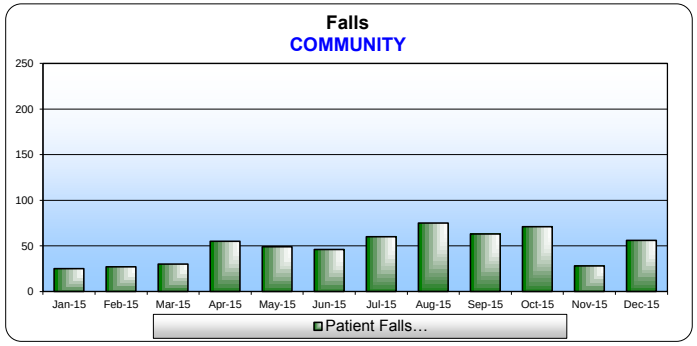


Measures of Harm

Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Patient Falls source: DATIX	York	148	173	207	147	166	150	145	145	179	156	121	152
	Scarborough	69	72	97	81	90	86	61	78	89	63	85	76
	Community	25	27	30	55	49	46	60	75	63	71	28	56

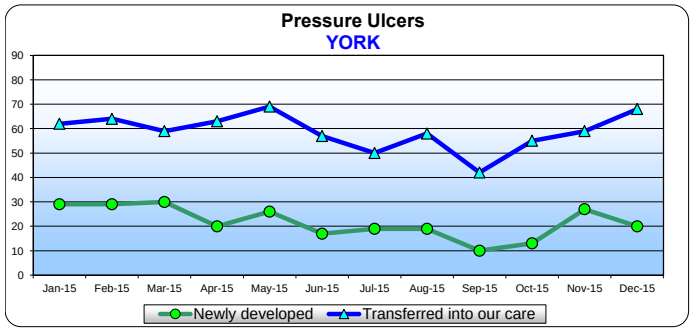


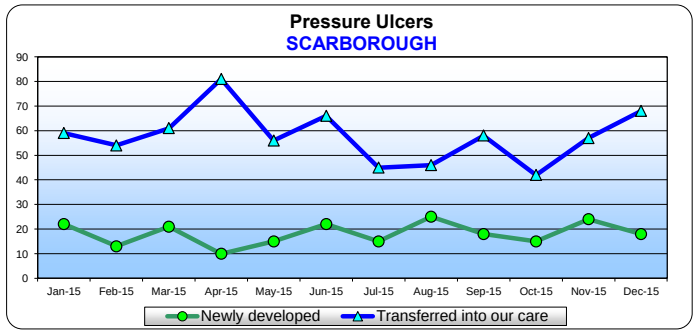


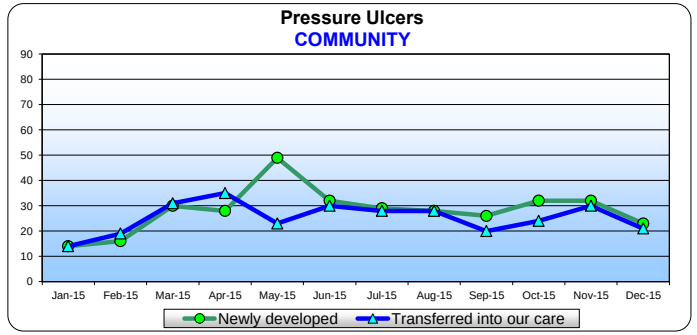


Note - Falls are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, and incidents which have been 'Rejected' are excluded.

Indicator			Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Pressure Ulcers source: DATIX	York	Newly developed	29	29	30	20	26	17	19	19	10	13	27	20
		Transferred into our care	62	64	59	63	69	57	50	58	42	55	59	68
	Scarborough	Newly developed	22	13	21	10	15	22	15	25	18	15	24	18
		Transferred into our care	59	54	61	81	56	66	45	46	58	42	57	68
	Community	Newly developed	14	16	30	28	49	32	29	28	26	32	32	23
		Transferred into our care	14	19	31	35	23	30	28	28	20	24	30	21



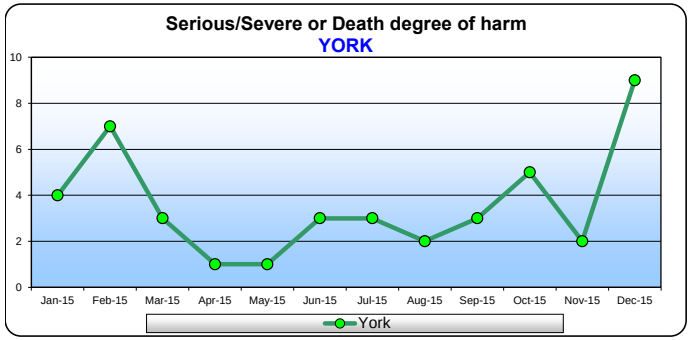


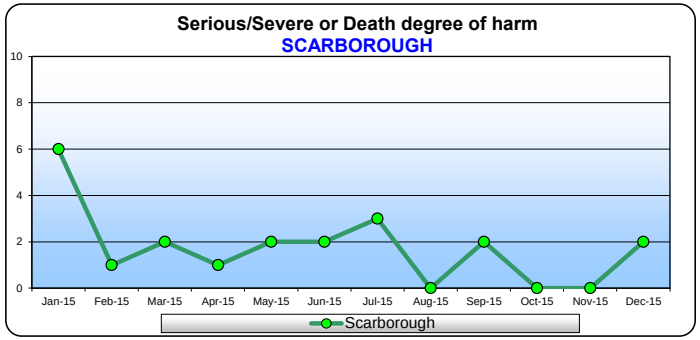


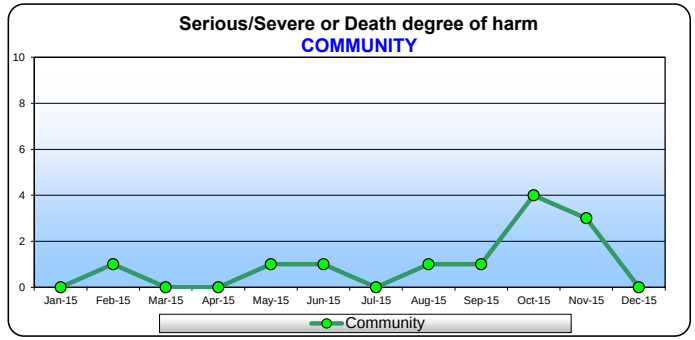
Note - Pressure Ulcers are reviewed retrospectively therefore totals will change month on month. Monthly figures will be refreshed each time the report is updated.
Totals include all degrees of harm, incidents which have been 'Rejected' are excluded as are pressure ulcers which have been categorised as a 'Deterioration of a previously reported ulcer'.

Measures of Harm

Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Degree of harm: serious/severe or death source: Datix	York	4	7	3	1	1	3	3	2	3	5	2	9
	Scarborough	6	1	2	1	2	2	3	0	2	0	0	2
	Community	0	1	0	0	1	1	0	1	1	4	3	0

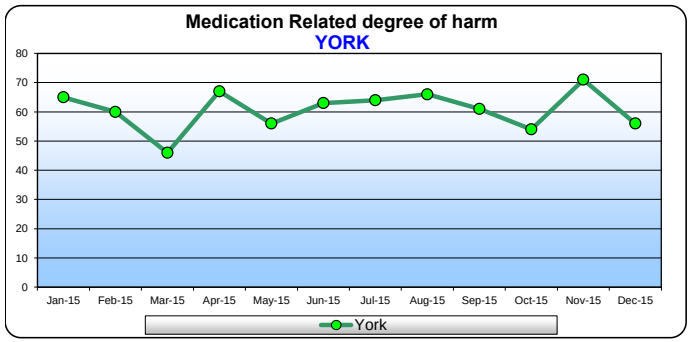


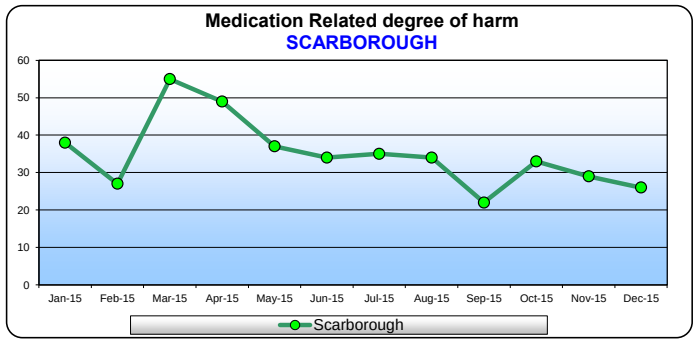


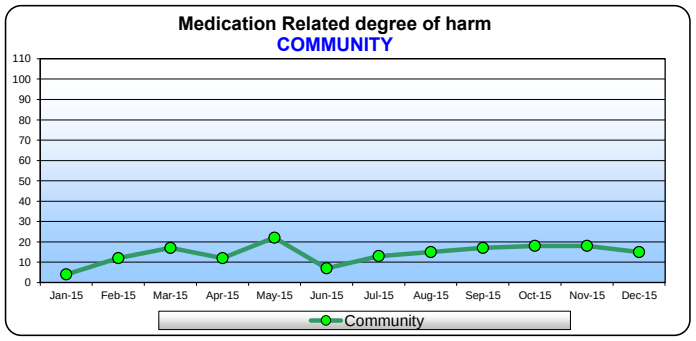


Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Degree of harm: Medication Related Issues source: Datix	York	65	60	46	67	56	63	64	66	61	54	71	56
	Scarborough	38	27	55	49	37	34	35	34	22	33	29	26
	Community	4	12	17	12	22	7	13	15	17	18	18	15

Please note: December increase in Medication Related issues is due to a new option of Medication being added to DATIX at the beginning of December. These were not previously recorded on DATIX.

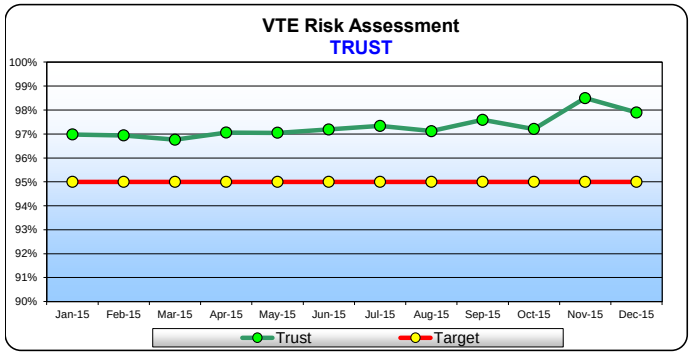


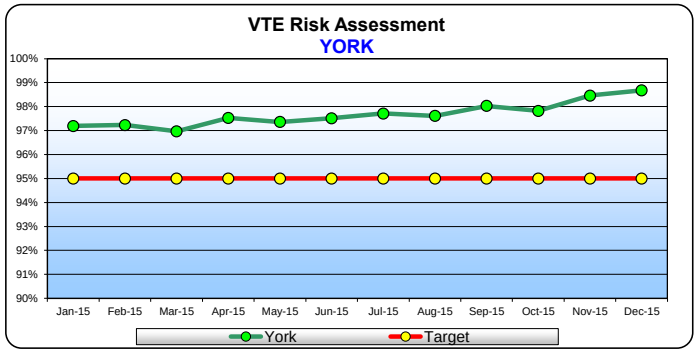


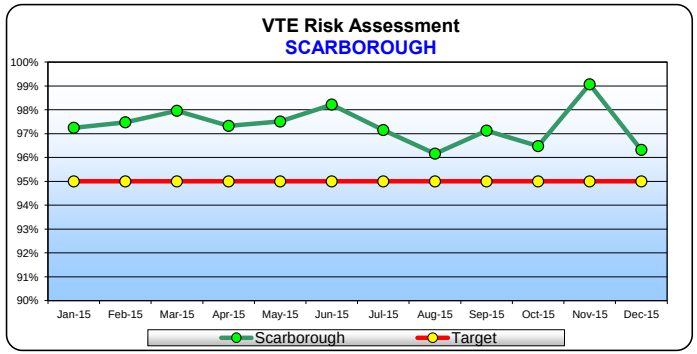


Measures of Harm

Indicator	Consequence of Breach	Site	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance source: CPD	£200 in respect of each excess breach above threshold	Trust	95%	96.9%	97.1%	97.4%	97.9%	97.2%	98.5%	97.9%
		York	95%	97.1%	97.5%	97.8%	98.3%	97.8%	98.5%	98.7%
		Scarborough	95%	97.6%	97.7%	96.8%	97.3%	96.5%	99.1%	96.3%







Never Events

Indicator	Consequence of Breach	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
SURGICAL									
Wrong site surgery	As below	**>0**	**0**	**1**	**0**	**0**	0	0	0
Wrong implant/prosthesis		**>0**	**0**	**0**	**0**	**0**	0	0	0
Retained foreign object post-operation		**>0**	**0**	**0**	**0**	**0**	0	0	0
MEDICATION									
Wrongly prepared high-risk injectable medication	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	**0**	0	0	0
Maladministration of potassium-containing solutions		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of chemotherapy		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong route administration of oral/enteral treatment		**>0**	**0**	**0**	**0**	**0**	0	0	0
Intravenous administration of epidural medication		**>0**	**0**	**0**	**0**	**0**	0	0	0
Maladministration of insulin		**>0**	**0**	**0**	**0**	**0**	0	0	0
Overdose of midazolam during conscious sedation		**>0**	**0**	**0**	**0**	**0**	0	0	0
Opioid overdose of an opioid-naïve Service User		**>0**	**0**	**0**	**0**	**0**	0	0	0
Inappropriate administration of daily oral methotrexate		**>0**	**0**	**0**	**0**	**0**	0	0	0
GENERAL HEALTHCARE									
Falls from unrestricted windows	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	**0**	**0**	**0**	**0**	0	0	0
Entrapment in bedrails		**>0**	**0**	**0**	**0**	**0**	0	0	0
Transfusion of ABO incompatible blood components		**>0**	**0**	**0**	**0**	**0**	0	0	0
Transplantation of ABO incompatible organs as a result of error		**>0**	**0**	**0**	**0**	**0**	0	0	0
Misplaced naso- or oro-gastric tubes		**>0**	**0**	**0**	**0**	**0**	0	0	0
Wrong gas administered		**>0**	**0**	**0**	**0**	**0**	0	0	0
Failure to monitor and respond to oxygen saturation		**>0**	**0**	**0**	**0**	**0**	0	0	0
Air embolism		**>0**	**0**	**0**	**0**	**0**	0	0	0
Misidentification of Service Users		**>0**	**0**	**0**	**0**	**0**	0	0	0
Severe scalding of Service Users		**>0**	**0**	**0**	**0**	**0**	0	0	0
	MATERNITY								
Maternal death due to post-partum haemorrhage after elective caesarean section	As above	**>0**	**0**	**0**	**0**	**0**	0	0	0

Drug Administration

Omitted Critical Medicines
The audit of critical medicines missed during December indicated 0.63% for York and 2.70% for Scarborough.

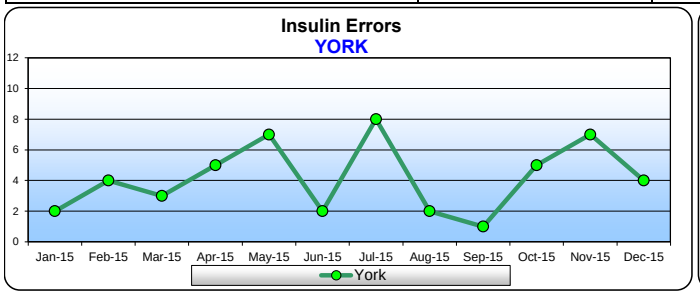
Prescribing Errors
There were 20 prescribing related errors in December; 12 from York, 5 from Scarborough and 3 from Community.

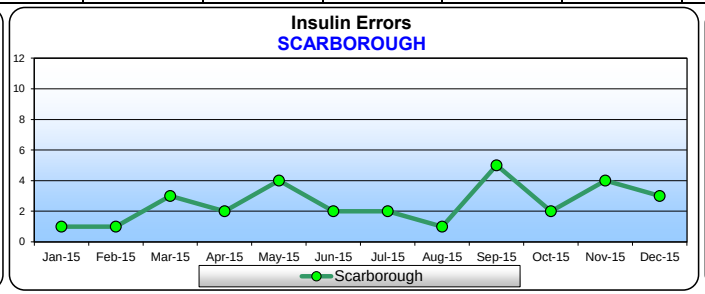
Preparation and Dispensing Errors
There were 10 preparation/dispensing errors in December; 5 from York, 5 from Scarborough and 0 from Community.

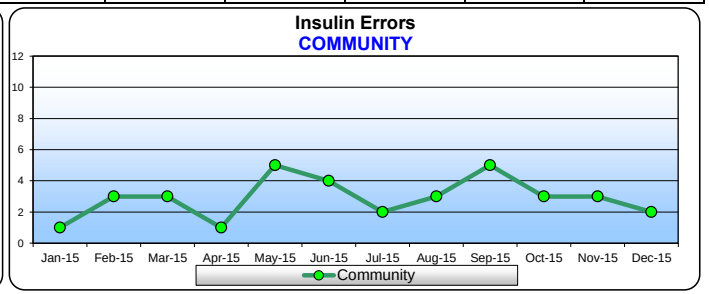
Administrating and Supply Errors
There were 44 administrating/supplying errors in December; 21 from York, 14 from Scarborough and 9 from Community.

Drug Administration

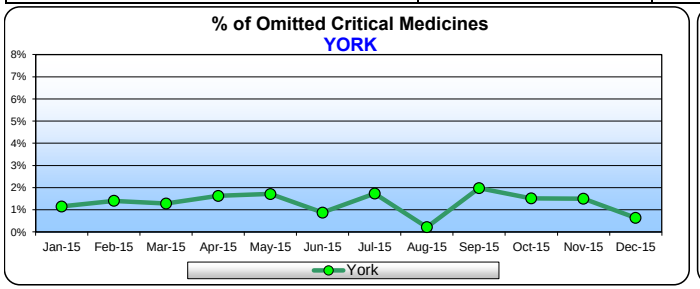
Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Insulin Errors source: Datix	York	2	4	3	5	7	2	8	2	1	5	7	4
	Scarborough	1	1	3	2	4	2	2	1	5	2	4	3
	Community	1	3	3	1	5	4	2	3	5	3	3	2

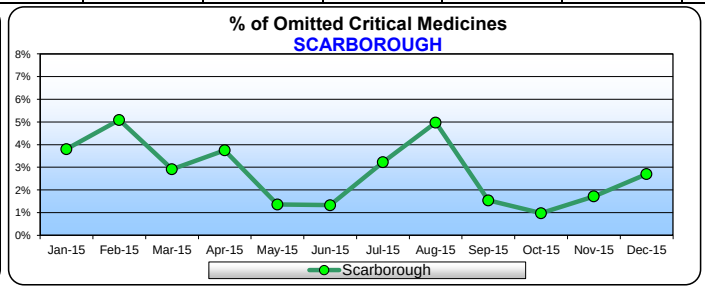


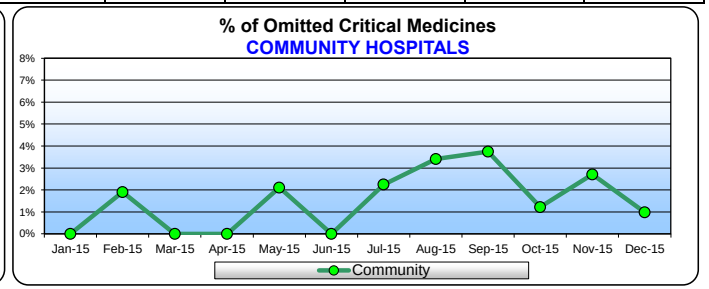




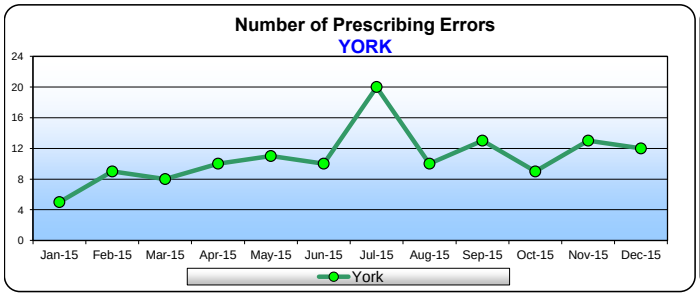
Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Number of Omitted Critical Medicines source: Datix	York	6	6	6	7	9	4	8	1	9	6	6	3
	Scarborough	9	12	7	9	3	3	7	10	3	2	4	7
	Community Hospitals	Not Available	2	Not Available	Not Available	2	Not Available	2	3	3	1	2	1

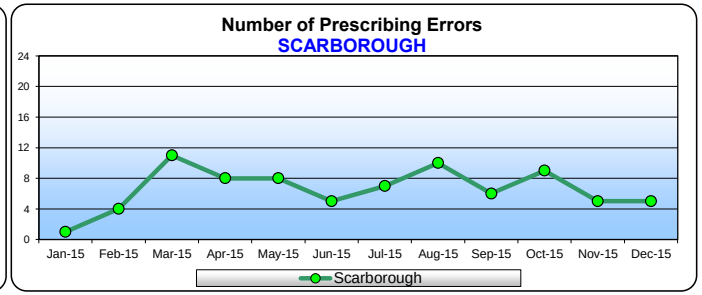


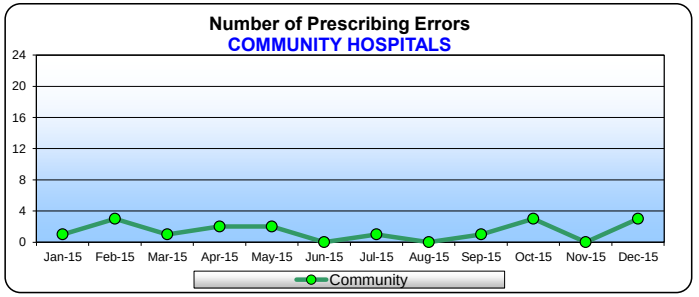




Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Number of Prescribing Errors source: Datix	York	5	9	8	10	11	10	20	10	13	9	13	12
	Scarborough	1	4	11	8	8	5	7	10	6	9	5	5
	Community Hospitals	1	3	1	2	2	0	1	0	1	3	0	3

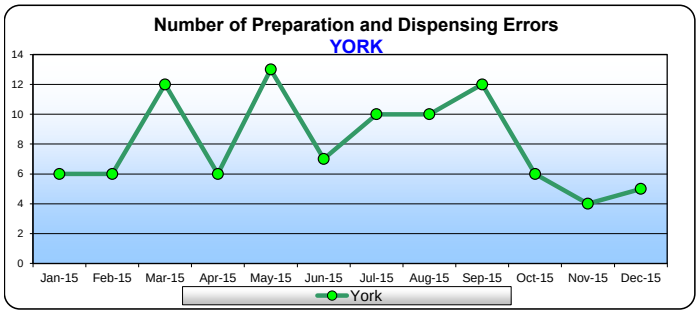


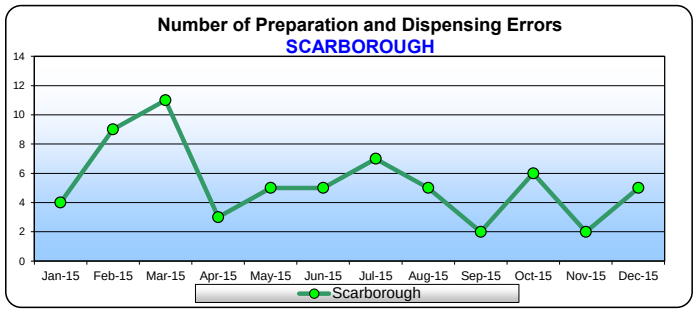


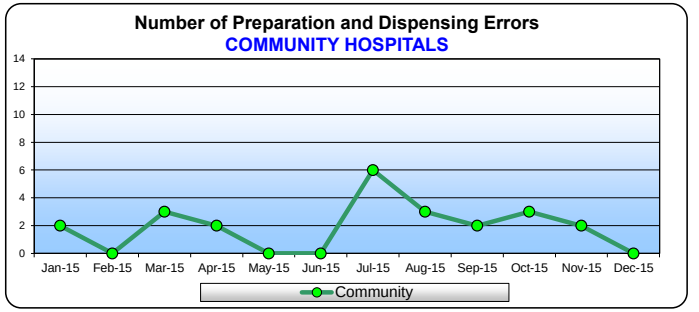


Drug Administration

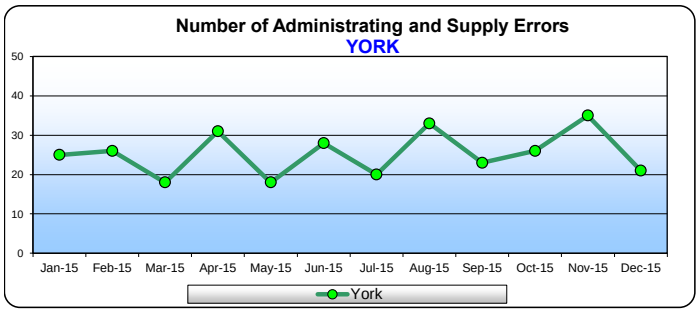
Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Number of Preparation and Dispensing Errors source: Datix	York	6	6	12	6	13	7	10	10	12	6	4	5
	Scarborough	4	9	11	3	5	5	7	5	2	6	2	5
	Community Hospitals	2	0	3	2	0	0	6	3	2	3	2	0

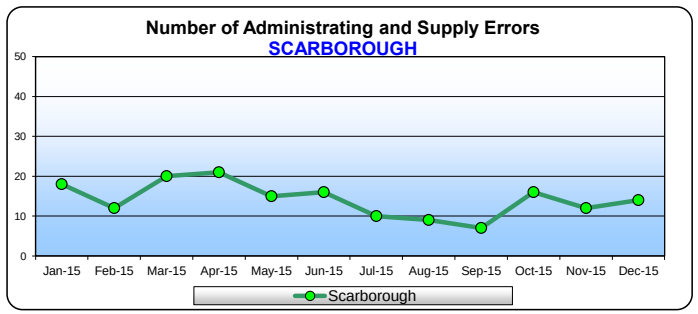


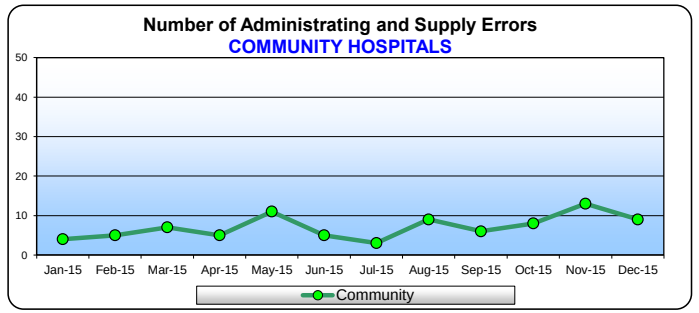




Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Administrating and Supply Errors source: Datix	York	25	26	18	31	18	28	20	33	23	26	35	21
	Scarborough	18	12	20	21	15	16	10	9	7	16	12	14
	Community Hospitals	4	5	7	5	11	5	3	9	6	8	13	9







Measures of Harm: Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month.

Harm Free Care

The percentage of patients harm free from pressure ulcers, catheter associated urinary tract infection (CAUTI), falls and VTE is measured as a monthly prevalence score. In December the percentage receiving care “free from harm” following audit is below:

·York: 92.7%
·Scarborough: 90.2%
·Community Hospitals: 83.5%
·Community care: 97.2%

Harm from Catheter Associated Urinary Tract Infection

The percentage of patients affected by CAUTI as measured by the Department of Health data definition, monthly measurement of prevalence:

·York: 1.9%
·Scarborough: 3.6%
·Community Hospitals: 0%
·Community Care: 0.2%

VTE

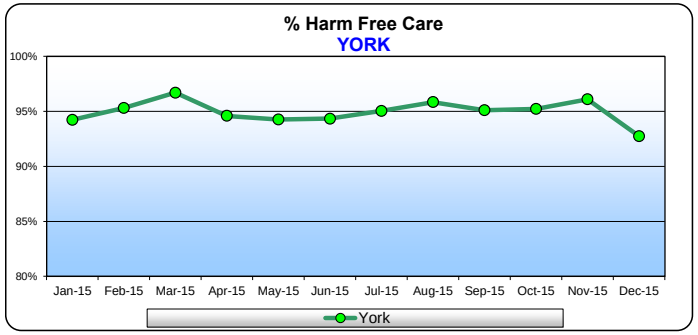
The percentage of patients affected by VTE as measured by the Department of Health definition, monthly measurement of prevalence:

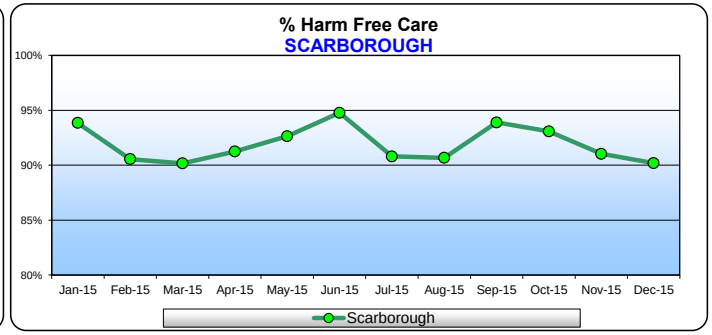
·York: 0.9%
·Scarborough: 0.7%
·Community Hospitals: 1.0%
·Community Care: 0.2%

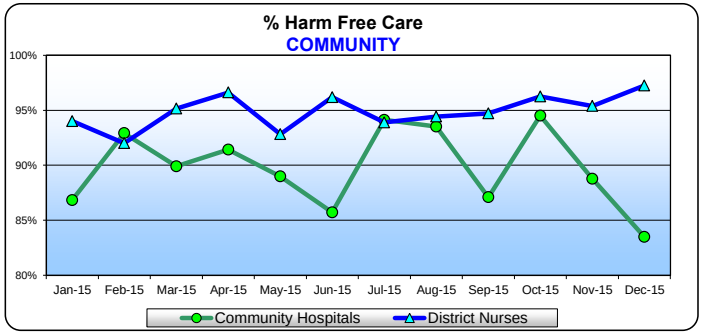
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

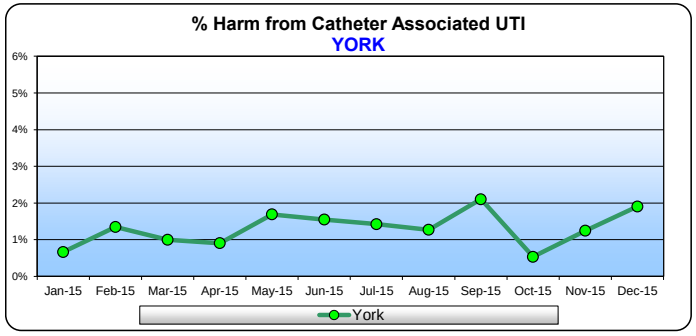
Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
% of Harm Free Care source: Safety Thermometer	York	94.2%	95.3%	96.7%	94.6%	94.3%	94.3%	95.0%	95.8%	95.1%	95.2%	96.1%	92.7%
	Scarborough	93.9%	90.6%	90.2%	91.3%	92.6%	94.8%	90.8%	90.7%	93.9%	93.1%	91.0%	90.2%
	Community Hospitals	86.8%	92.9%	89.9%	91.4%	89.0%	85.7%	94.1%	93.5%	87.1%	94.5%	88.8%	83.5%
	District Nurses	94.0%	92.0%	95.2%	96.6%	92.8%	96.2%	93.9%	94.4%	94.7%	96.2%	95.4%	97.2%

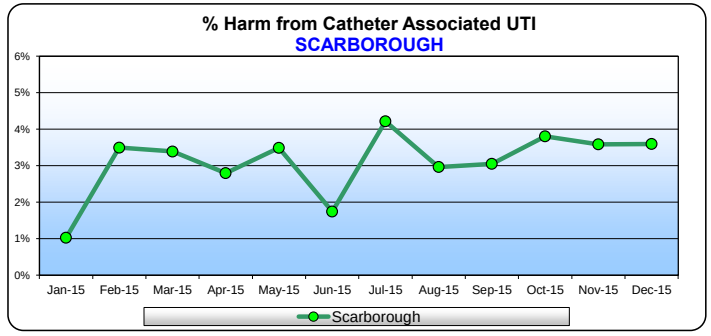


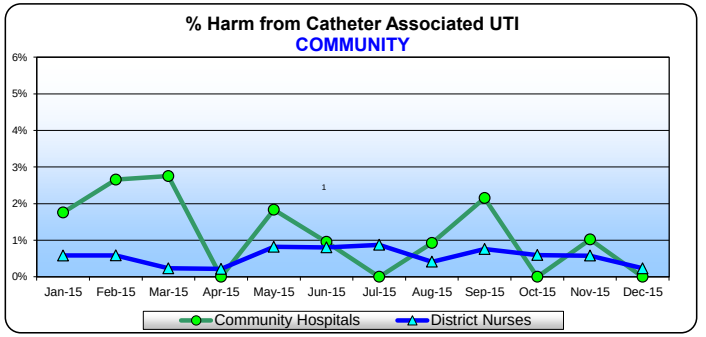




Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
% of Harm from Catheter Associated Urinary Tract Infection source: Safety Thermometer	York	0.7%	1.3%	1.0%	0.9%	1.7%	1.5%	1.4%	1.3%	2.1%	0.5%	1.2%	1.9%
	Scarborough	1.0%	3.5%	3.4%	2.8%	3.5%	1.7%	4.2%	3.0%	3.1%	3.8%	3.6%	3.6%
	Community Hospitals	1.8%	2.7%	2.8%	0.0%	1.8%	1.0%	0.0%	0.9%	2.2%	0.0%	1.0%	0.0%
	District Nurses	0.6%	0.6%	0.2%	0.2%	0.8%	0.8%	0.9%	0.4%	0.8%	0.6%	0.6%	0.2%



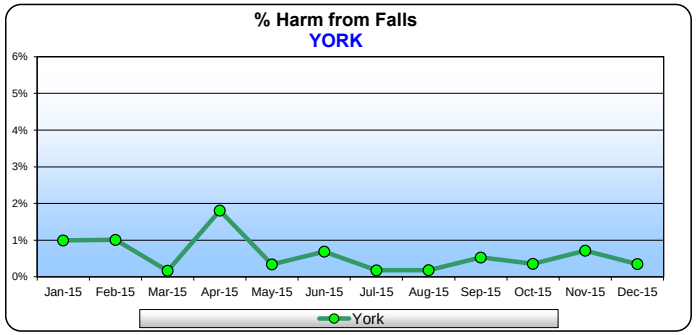


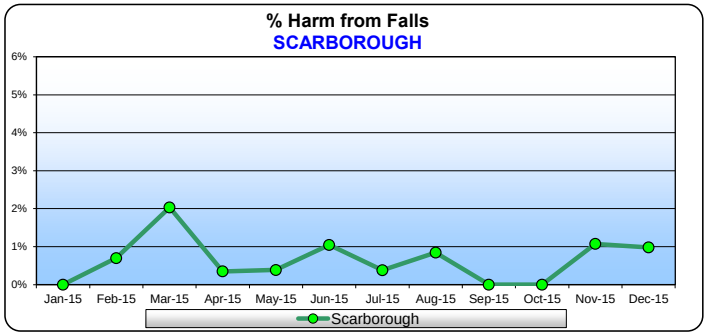


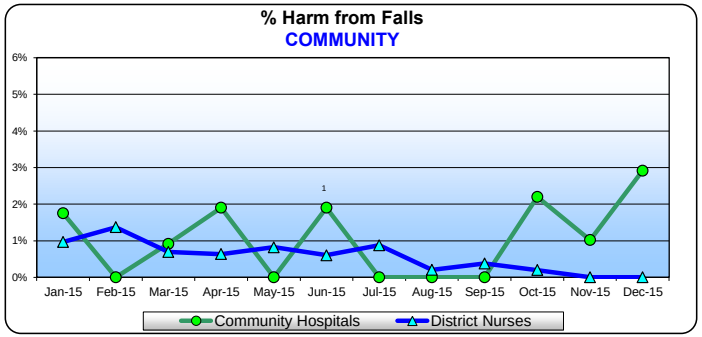
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

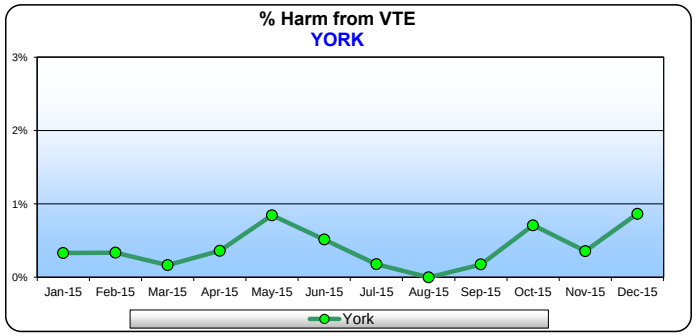
Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
% of Harm from Falls source: Safety Thermometer	York	1.0%	1.0%	0.2%	1.8%	0.3%	0.7%	0.2%	0.2%	0.5%	0.4%	0.7%	0.3%
	Scarborough	0.0%	0.7%	2.0%	0.3%	0.4%	1.0%	0.4%	0.8%	0.0%	0.0%	1.1%	1.0%
	Community Hospitals	1.8%	0.0%	0.9%	1.9%	0.0%	1.9%	0.0%	0.0%	0.0%	2.2%	1.0%	2.9%
	District Nurses	1.0%	1.4%	0.7%	0.6%	0.8%	0.6%	0.9%	0.2%	0.4%	0.2%	0.0%	0.0%

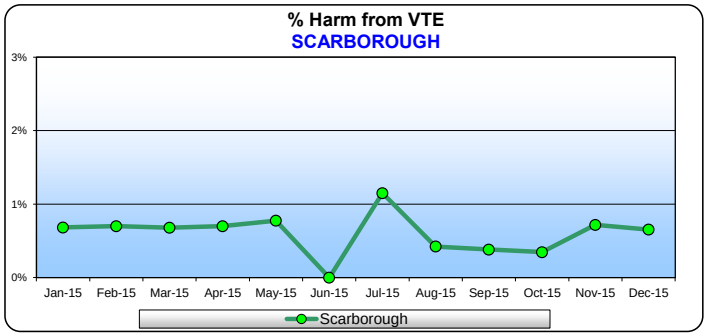


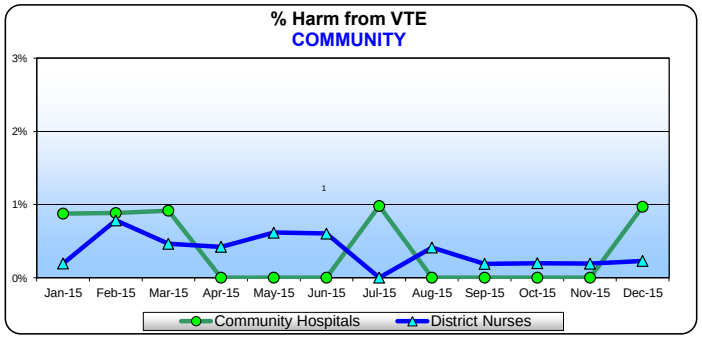




Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
% of VTE source: Safety Thermometer	York	0.3%	0.3%	0.2%	0.4%	0.8%	0.5%	0.2%	0.0%	0.2%	0.7%	0.4%	0.9%
	Scarborough	0.7%	0.7%	0.7%	0.7%	0.8%	0.0%	1.1%	0.4%	0.4%	0.3%	0.7%	0.7%
	Community Hospitals	0.9%	0.9%	0.9%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	1.0%
	District Nurses	0.2%	0.8%	0.5%	0.4%	0.6%	0.6%	0.0%	0.4%	0.2%	0.2%	0.2%	0.2%



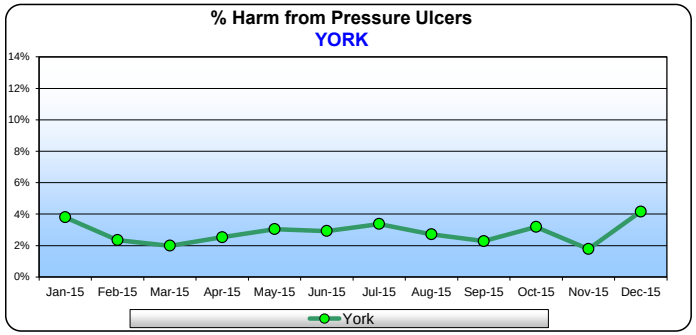


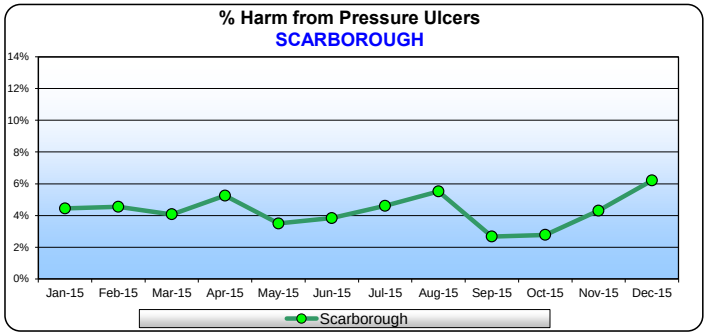


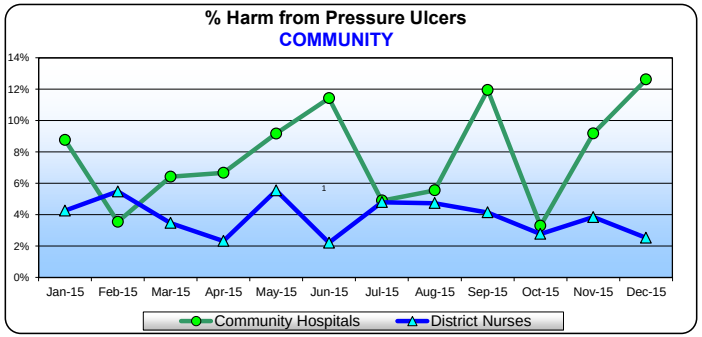
Safety Thermometer

Please note this Safety Thermometer is a snapshot taken on the first Wednesday of the month. Whitecross Court and St Helen's are not included in the Community Hospital figures as they are part of the acute bed base.

Indicator		Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
% of Pressure Ulcers source: Safety Thermometer	York	3.8%	2.3%	2.0%	2.5%	3.0%	2.9%	3.4%	2.7%	2.3%	3.2%	1.8%	4.2%
	Scarborough	4.4%	4.5%	4.1%	5.2%	3.5%	3.8%	4.6%	5.5%	2.7%	2.8%	4.3%	6.2%
	Community Hospitals	8.8%	3.5%	6.4%	6.7%	9.2%	11.4%	4.9%	5.6%	12.0%	3.3%	9.2%	12.6%
	District Nurses	4.3%	5.5%	3.5%	2.3%	5.5%	2.2%	4.8%	4.7%	4.2%	2.8%	3.8%	2.5%







Mortality

Indicator	Jul 11 - Jun 12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15
SHMI – York locality	105	105	102	98.7986	96	93	93	95	98	99	97	96
SHMI – Scarborough locality	117	112	106	107.7479	108	104	105	107	108	109	107	108
SHMI – Trust	**108**	**107**	**104**	**102**	**101**	**97**	**98**	**99**	**102**	**103**	**101**	**101**

Definition

SHMI: The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England using a standard methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute NHS trusts in England and either die while in hospital or within 30 days of discharge.

RAMI: Risk Adjusted Mortality Index uses a methodology to calculate the risk of death for hospital patients on the basis of clinical and hospital characteristic data including age, sex, length of stay, method of admission, HRG, ICD10 primary and secondary diagnosis, OPCS primary and secondary procedures and discharge method. Unlike SHMI, it does not include deaths after discharge. The Trust is not managed externally on its RAMI score.

Analysis of Performance

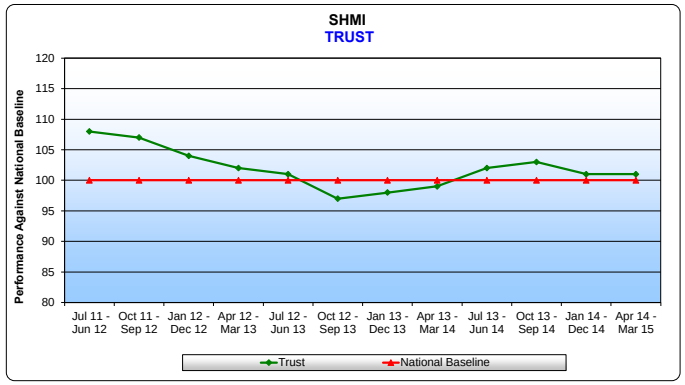
The latest SHMI report indicates the Trust to be in the 'as expected' range. The Apr 14 - Mar 15 SHMI remained static at 101 , with York seeing a 1 point reduction and Scarborough seeing a 1 point increase.

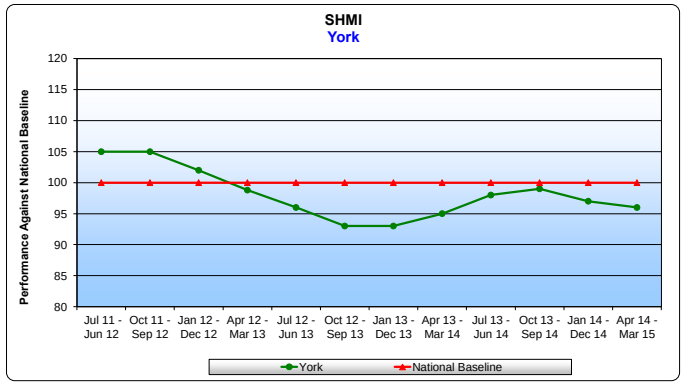
The number of inpatient deaths in December was in line with previous months. The percentage of deaths against all discharges at York has increased from 1.1% in November to 1.4% in December (December 2014 was 1.3%). Scarborough also saw a increase from 1.4% in November to 1.7% in December (December 2014 was 2.4%).

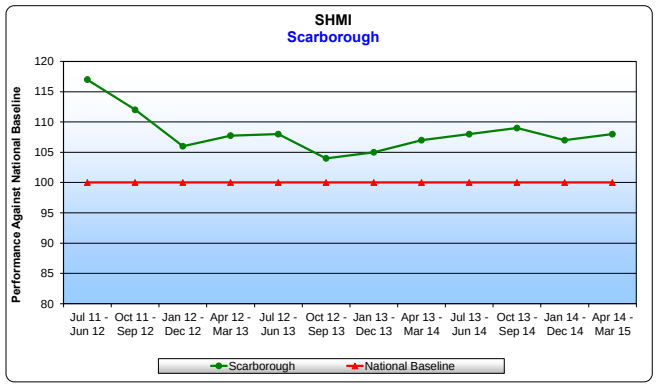
The number of ED deaths in December was in line with previous months at Scarborough (4), however the number at York was out of normal range (17). The last time the number of ED deaths was this high at York was in August 2013.

Mortality

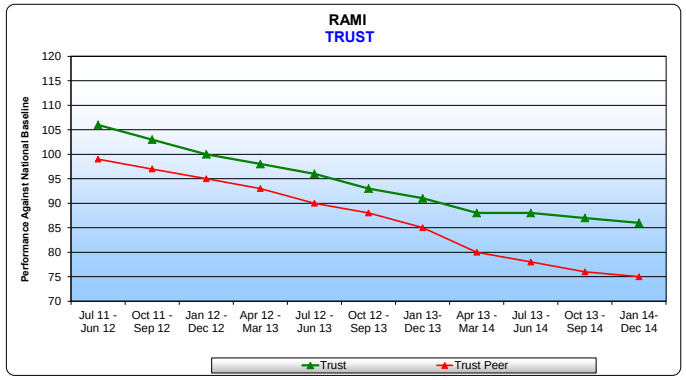
Indicator	Consequence of Breach (Monthly unless specified)	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15
Mortality – SHMI (TRUST)	**Quarterly:** General Condition 9	97	98	99	102	103	101	101
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	93	93	95	98	99	97	96
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9	104	105	107	108	109	107	108

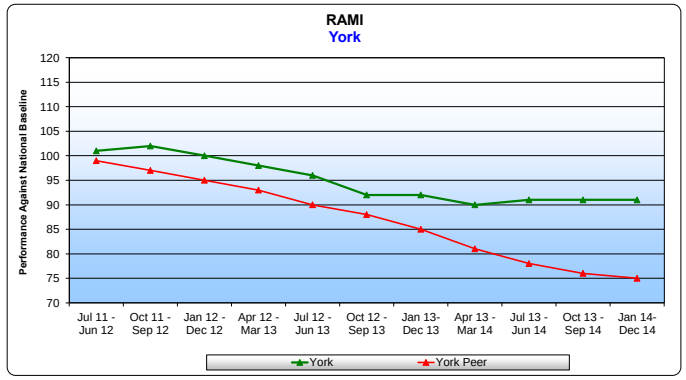


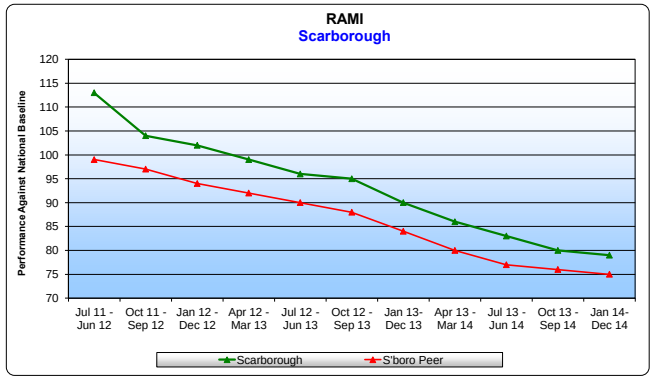




Indicator	Consequence of Breach (Monthly unless specified)	Jul 12 - Jun 13	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sept 14	Jan 14 - Dec 14
Mortality – RAMI (TRUST)	**none - monitoring only**	96	93	91	88	88	87	86
Mortality – RAMI (YORK)	**none - monitoring only**	96	92	92	90	91	91	91
Mortality – RAMI (SCARBOROUGH)	**none - monitoring only**	96	95	90	86	83	80	79

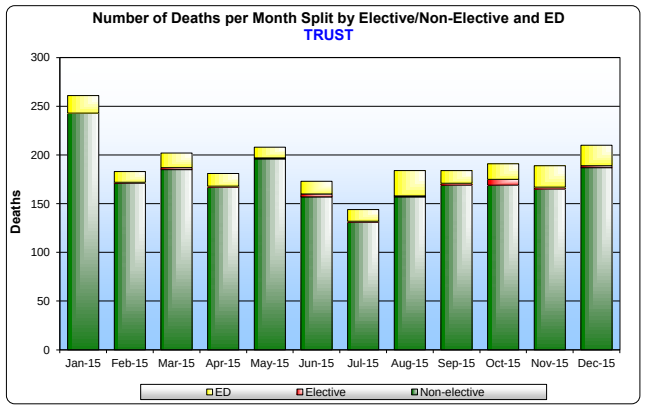


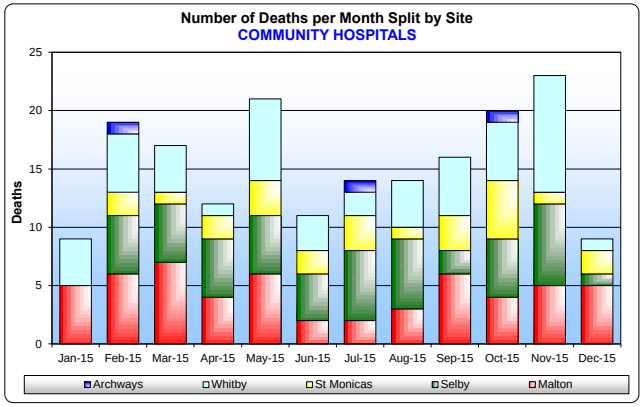




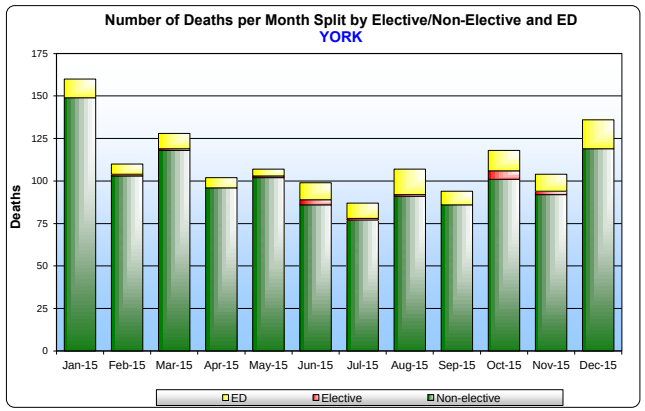
Mortality

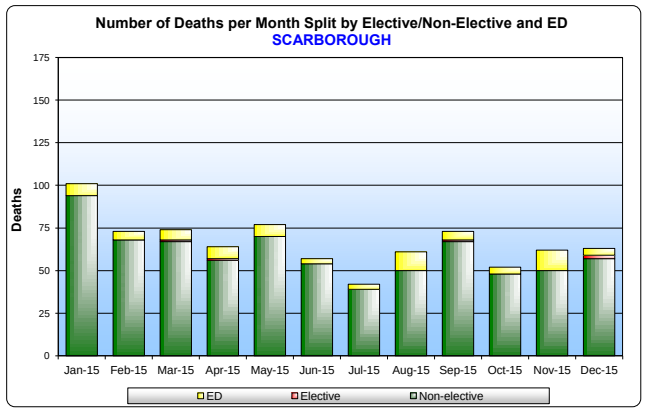
Indicator	Consequence of Breach (Monthly unless specified)	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Number of Inpatient Deaths (excludes deaths in ED)	None - Monitoring Only	602	525	461	531	175	167	189

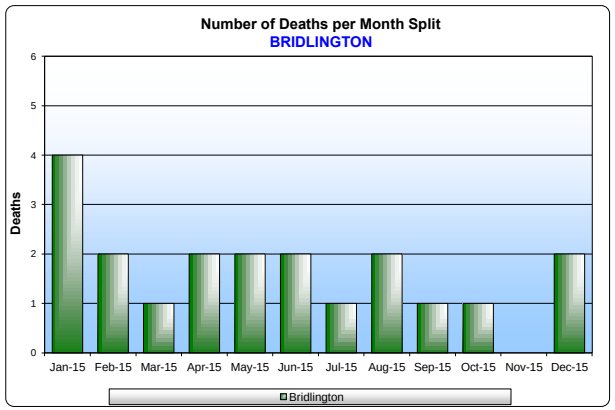




Month	Malton	Selby	St Monicas	Whitby	Archways	Bridlington
Jan-15	5	0	0	4	0	4
Feb-15	6	5	2	5	1	2
Mar-15	7	5	1	4	0	1
Apr-15	4	5	2	1	0	2
May-15	6	5	3	7	0	2
Jun-15	2	4	2	3	0	2
Jul-15	2	6	3	2	1	1
Aug-15	3	6	1	4	0	2
Sep-15	6	2	3	5	0	1
Oct-15	4	5	5	5	1	1
Nov-15	5	7	1	10	0	0
Dec-15	5	1	2	1	0	2





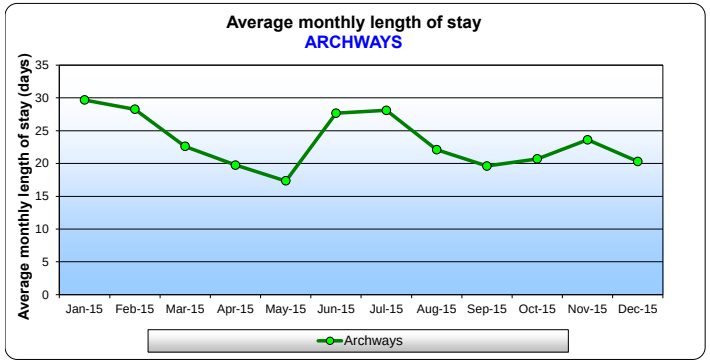


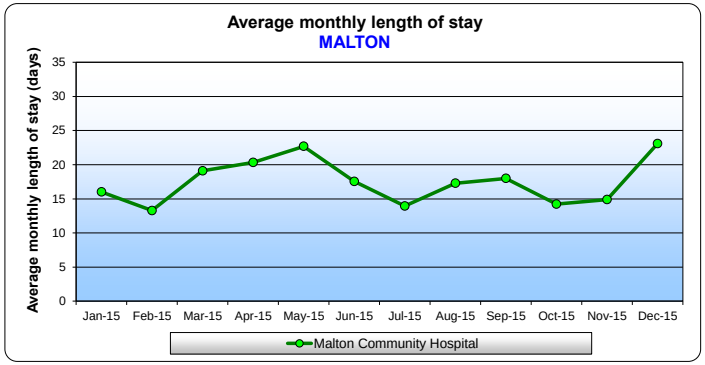
Patient Safety Walkrounds – December 2015

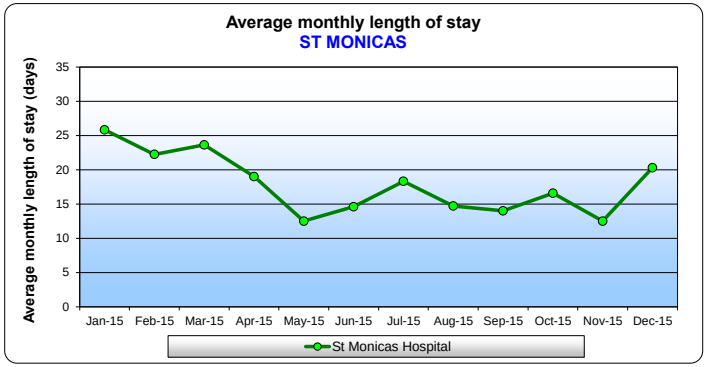
Date	Location	Participants	Actions & Recommendations
03/12/2015	Ash Ward and Aspen Unit	Diane Palmer - Deputy Director Gemma Ellison – Directorate Manager Beth Horsman – Matron Tariq Hoth – Clinical Director	Report to follow.
09/12/2015	Therapies Directorate - Haworth Unit Physio and OT Department, Main MSK Physio Department, Orthotic Department	Helen Hey - Deputy Director Mel Liley – Directorate Manager Sandra Van Der Kooj – Lead OT Sue Sharp – Lead for Orthotics Sue Symington - NED	The AHP and Psychological medicine Directorate does not have a Clinical Director to raise issues at a senior level - Sue Symington to take this to the executive team. Staff coats are kept in the patient area, in the Haworth Gym - Sandra van der Kooij to ensure these are removed. The hand washing sink is obstructed by a table and chairs - Sandra van der Kooij to ensure this is rectified. The Neurological Nurses Office has had water ingress causing the door to no longer close. There is a patient confidentiality and security issue - Helen Hey to raise with Emma George. The work that has been done in the new outpatient treatment room has not been handed over satisfactorily, and some snags remain - Sandra van der Kooij to liaise with Andy Betts and Jo Southwell to finalise the works. The old reception desk still has its shutter and is confusing for patients - Sandra van der Kooij to liaise with Andy Betts and Jo Southwell regarding removing the shutter and making good. There is to be a new Physiotherapy outpatient space in the Haworth Unit that patients should be involved in - Emily Dervey and Sue Sharp will arrange this once we have some plans for phase two.
15/12/2015	Holly Ward	Diane Palmer - Deputy Director Liz Charters - Matron Jennie Adams – NED	Report to follow.
23/12/2015	Outpatients (York)	Patrick Crowley – Chief Executive Tariq Hoth – Clinical Director Gemma Ellison – Directorate Manager Pauline Guyan - Matron Mike Sweet – NED	Patient case notes in the corridors – discussed the possibility of clinics using only electronic case records.. Redevelopment of the courtyard spaces is necessary to improve appearance and storage space. There is insufficient clinic space during 9-5 Monday to Friday sessions and therefore greater use must be made of the facility in the evening and at weekends.

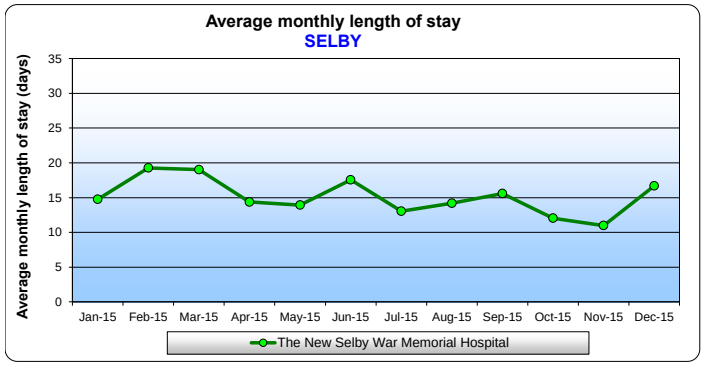
Community Hospitals

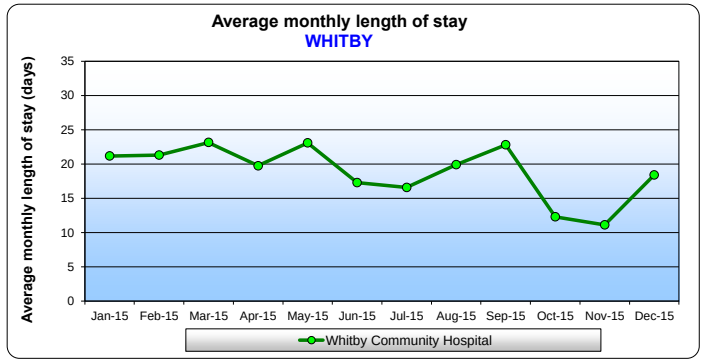
Indicator	Hospital	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Community Hospitals average length of stay (days)	Archways	26.8	21.1	23.0	21.3	20.7	23.6	20.3
	Malton Community Hospital	16.0	19.9	16.1	17.3	14.2	14.9	23.1
	St Monicas Hospital	24.0	15.5	15.5	16.7	16.6	12.5	20.3
	The New Selby War Memorial Hospital	17.6	15.3	14.2	13.3	12.1	11.0	16.7
	Whitby Community Hospital	21.9	20.0	19.5	12.8	12.3	11.1	18.4
	Total	20.2	18.5	17.4	15.5	14.1	13.5	19.7

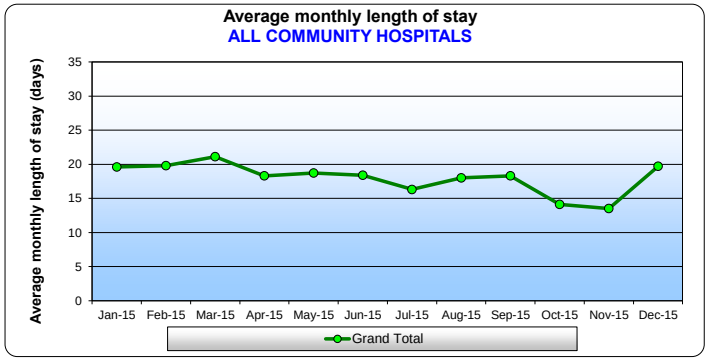






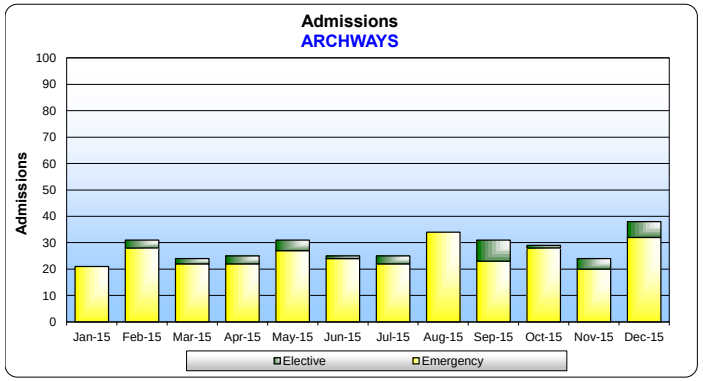


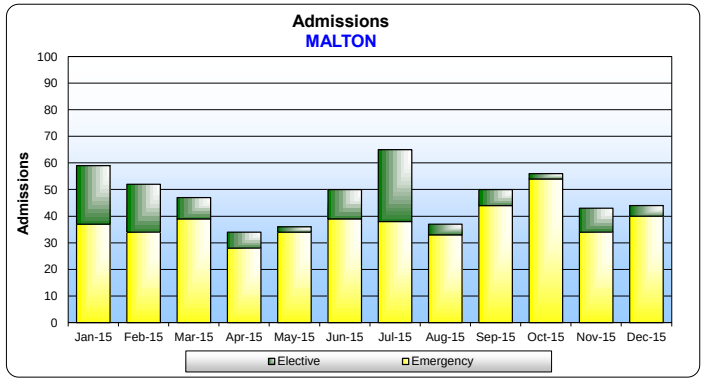


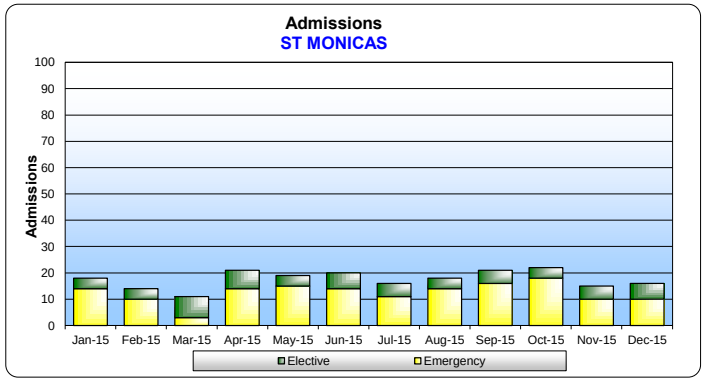


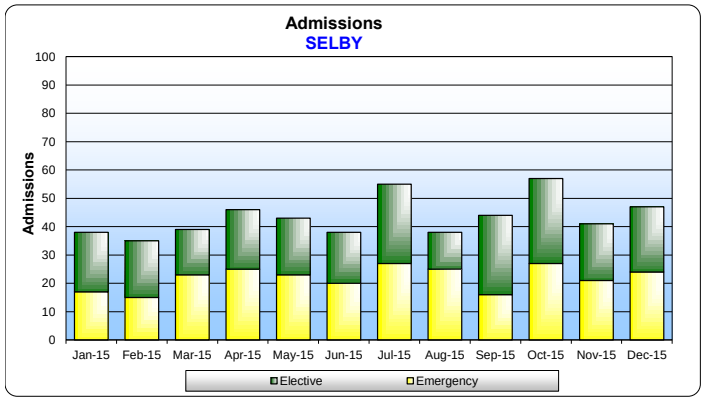
Community Hospitals

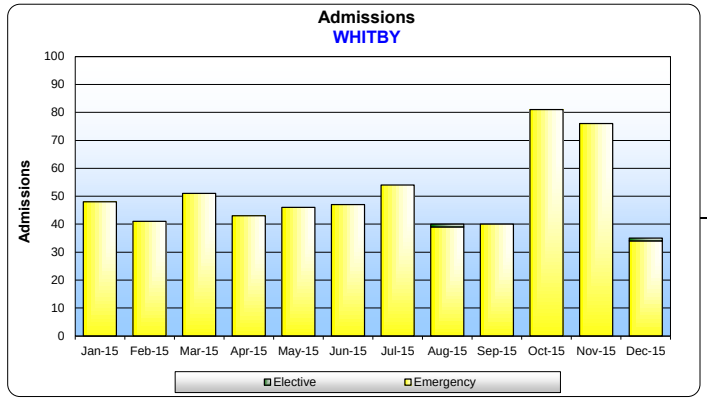
Indicator	Hospital		Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Community Hospitals admissions Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	5	8	11	11	1	4	6
		Emergency	71	73	79	80	28	20	32
	Malton Community Hospital	Elective	48	19	37	15	2	9	4
		Emergency	110	101	115	128	54	34	40
	St Monicas Hospital	Elective	16	17	14	15	4	5	6
		Emergency	27	43	41	38	18	10	10
	The New Selby War Memorial	Elective	57	59	69	73	30	20	23
		Emergency	55	68	68	72	27	21	24
	Whitby Community Hospital	Elective	0	0	1	1	0	0	1
		Emergency	140	136	133	191	81	76	34
	Total	Elective	126	121	122	115	37	38	40
		Emergency	403	441	508	509	208	161	140

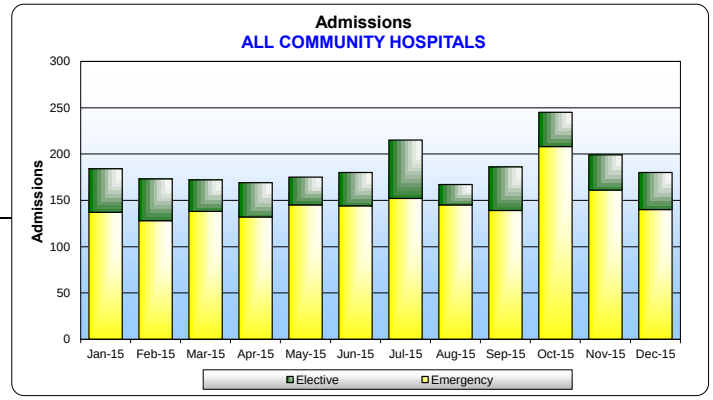












Blank page

D2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 27 January 2016

Medical Director's Report

Action requested/recommendation

Board of Directors is asked to:

- Note the update on SHMI
- Note the update on winter pressures
- Be aware of progress with the flu vaccinations campaign
- Note the results of the antibiotic prescribing audit within their Directorates and to ensure that where necessary actions are taken for improvement
- Be aware of progress with the Patient Safety Strategy/Sign up to Safety Campaign
- Note consultants new to the Trust.

Summary

This report provides an update from the Medical Director on Patient Safety related issues.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Reference to CQC outcomes

There are no direct references to CQC outcomes, although most indicators in this report are monitored as part of CQC regulation compliance.

Progress of report	The contents of this report have been discussed at Quality and Safety Committee and Executive Board.
Risk	No additional risks have been identified other than those specifically referenced in the paper.
Resource implications	None identified.
Owner	Mr James Taylor, Medical Director
Author	Diane Palmer, Deputy Director of Patient Safety
Date of paper	January 2016
Version number	1

Board of Directors - 27 January 2016

Medical Director's Report

1. Introduction and background

In the report this month:

- Update on the current SHMI
- Update on winter pressures
- Update on flu campaign
- Antimicrobial Prescribing Audit
- Patient Safety Strategy/Sign up to Safety Campaign update
- Consultants new to the Trust.

2. Winter Pressures

Impact of winter pressures on patient safety

Delay beyond our control in discharging patients back to the community results in lack availability of acute hospital beds which adds to flow pressures in the hospital and impacts on admissions from the Emergency Departments (EDs). The lack of acute bed capacity due to delayed discharges may also delay transfer patients from our critical care unit.

Performance against the target that 95% of patients should spend no longer than four hours in our EDs continues to be very challenging for us but we have new plans to improve our performance which are having an impact. Some patients do experience long delays in the EDs which results in the potential for increased risk to patient safety. There were five patients during November who waited in excess of 12 hours for acute admission to hospital; four patients in Scarborough and one in York. All of the cases who experienced a delay of in excess of 12 hours are being reviewed by a consultant in acute medicine to determine if there was clinical harm as a result of the delay. No patients waited in excess of 12 hours for acute admission to our hospitals during December.

The impact of NHS England cap on agency payments which came into effect on 23rd November remains unknown but it is may influence our ability to recruit temporary staff and particular those staff we have relied on to support less popular shifts over a weekend and bank holidays.

3. Update on Flu Campaign

The Public health England National Influenza Report highlights recent increase in influenza activity including GP consultation rates, the proportion of positive influenza samples and admission of patients with influenza to acute hospital and critical care beds.
Up to 30th November the national data showed that 44% of frontline healthcare workers had received the influenza vaccine and the Trust figure for the same period was 40%. The latest figures for the Trust, up to 31st December indicate that 46.5 % of frontline staff had received the vaccine.

4. Antimicrobial prescribing audit

A summary of antibiotic prescription audit results for January - December 2015 are presented below.

Good progress continues on the recording of the indication for the antibiotic and the duration. The auditors were only able to identify the prescriber on 49% of occasions, which must be improved.

indication on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
York	85%	87%	89%	86%	82%	86%	91%	87%	86%	91%	86%	91%
Scarborough	81%	76%	86%	89%	90%	87%	93%	83%	82%	82%	86%	95%
Trust average	83%	82%	87%	87%	85%	87%	92%	86%	85%	88%	86%	92%

duration / course length on antibiotic prescription	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
York	84%	88%	91%	88%	82%	89%	91%	83%	81%	84%	76%	84%
Scarborough	84%	88%	85%	92%	90%	83%	89%	81%	84%	82%	91%	94%
Trust average	84%	88%	89%	89%	85%	86%	90%	82%	82%	83%	81%	87%

% of inpatients prescribed antibiotics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
York	24%	25%	23%	25%	21%	19%	19%	24%	23%	22%	24%	29%
Scarborough	36%	36%	27%	28%	26%	26%	32%	22%	28%	27%	24%	30%

Proportion of iv & oral antibiotics (Trust wide results)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
iv antibiotics	43.9 %	43.1 %	57.6 %	36.2 %	50.5 %	56.9 %	53.4 %	53.3 %	56.7 %	49.3 %	48.6 %	51.7 %
oral antibiotics	56.1 %	56.9 %	41.5 %	63.8 %	49.5 %	43.1 %	46.6 %	46.7 %	43.3 %	50.7 %	51.4 %	48.3 %

Can the prescriber be identified? (legible signature /bleep number)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% yes	/	/	/	/	/	/	44.3 %	54.6 %	61.9 %	59.6 %	56.7 %	49.0 %
% no	/	/	/	/	/	/	55.7 %	45.4 %	38.1 %	40.4 %	43.3 %	51.0 %

5. Patient Safety Strategy/Sign up to Safety Campaign - update

Severe sepsis

The Trust continues to make good progress with screening of patients for severe sepsis and we expect to achieve the Quarter 3 target. An electronic version of the sepsis screening tool has been developed by Systems and Networks which is currently under review and may be available for use within the next 2-3 weeks.

As the screening for sepsis continues to improve we are able to identify those patients who have severe sepsis and therefore require prompt initiation of the Sepsis 6 bundle of care. Whilst there has been improvement over the last nine months in our response time to complete the Sepsis 6, we are failing to achieve this in approximately 60% of cases. The requirement to administer antibiotics within one hour of the patient presenting with severe sepsis is proving particularly challenging in our Emergency Departments and Acute Medical Units.

Care of patient with diabetes
The Think Glucose Group continues to raise awareness of good practices in glucose monitoring and care of patients receiving insulin, however to expedite some of the work two local CQUIN indicators have been presented and agreed with commissioners. One programme will focus on analysis of errors with insulin omission, prescribing and administration within the medical and surgical assessment units. The other programme will focus on promoting effective monitoring of capillary blood glucose in acute elderly, medicine and vascular patients.

Trust Mortality Review
All Trusts have been asked by the National Medical Director for NHS England to conduct a self-assessment exercise of their avoidable mortality using a simple tool developed by NHS England. The self-assessment is to be completed by 31st January 2016. A Mortality Governance Guide has been developed by Monitor and the Trust Development Authority to help support Trust Boards to take a common and systematic approach to the issue of potentially avoidable mortality and to link this to quality improvement work. The Medical Director is currently reviewing the Guide and how this will be applied in the Trust.

6. Consultants new to the Trust

Dr Santhanakrishnan Balasubramanian
Consultant Renal Medicine
York

Dr Izzat Abdul-Kadir
Consultant Histopathology
York

7. Recommendations

Board of Directors is asked to:

- Note the update on SHMI
- Note the update on winter pressures
- Be aware of progress with the flu vaccinations campaign
- Note the results of the antibiotic prescribing audit within their Directorates and to ensure that where necessary actions are taken for improvement
- Be aware of progress with the Patient Safety Strategy/Sign up to Safety Campaign
- Note consultants new to the Trust.

Author	**Diane Palmer, Deputy Director of Patient Safety**
Owner	**Mr James Taylor, Medical Director**
Date	**January 2016**

Blank page

D3

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Chief Nurse Report - Quality of Care

Action requested/recommendation

The Board is asked to note the Chief Nurse report and acknowledge the significant progress made towards the delivery of the Nursing and Midwifery strategy.

Summary

The Chief Nurse report provides assurance against the implementation of the Nursing & Midwifery Strategy and evidence in support of our Quality Account. It outlines key priorities and progress

The Trust is now in the final months of its current Nursing & Midwifery strategy for 2013-2016 and this report highlights some of the achievements made and illustrates the significant progress against the strategy. Work is now underway to identify the key priorities for the next 3 years and this will be presented to the Board in the coming months.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Consideration is given to the equality and diversity issues during the development of the report including the impact of the care given to patients.

Reference to CQC regulations

Outcomes 4, 5, 8, 9, 16 & 17.

(Regulations can be found here: http://www.cqc.org.uk/content/regulations-service-providers-and-managers)

Progress of report	Executive Board Quality and Safety Committee
Risk	Associated risks have been assessed.
Resource implications	None identified.
Owner	Beverley Geary, Chief Nurse
Author	Beverley Geary, Chief Nurse
Date of paper	January 2016
Version number	Version 1

Board of Directors – 27 January 2016

Chief Nurse Report - Quality of Care

1. Introduction and Background

The Nursing & Midwifery Strategy was formally launched in September 2013 following consultation and collaboration with nurses throughout the organisation and taking into account patient feedback.

The strategy was aligned to national recommendations and the Chief Nursing Officers strategy for nursing (the '6C's') and has four focus areas:
Patient Experience
Delivering High Quality Safe Patient Care
Measuring the impact of care delivery
Staff Experience

This paper intends to highlight the progress made over the last three years, identify our successes and challenges with particular detail being provided on Nurse Staffing and recruitment activity which is currently on our Corporate Risk Register.

The strategy and its implementation plan was subject to internal audit in August of last year, the findings were of significant assurance. (appendix 1).

2. Delivery of the Nursing & Midwifery Strategy

During the last three years there has been increased focus and scrutiny placed on both the NHS and nursing in respect of patient care with notable and significant reports being published:

- The Francis Report - Inquiry into Mid Staffordshire NHS Foundation Trust
- "Hard Truths – The Journey of putting patients First"
- "How to ensure the right people, with the right skills, are in the right place at the right time" the National Quality Board,
- CQC Essential Standards
- NICE Safe Staffing for nursing in adult inpatient wards in acute hospitals
- Comprehensive Critical Care: A Review of Adult Critical Care Services

The Trust has considered each of these reports in relation to the care provided by our organisation and has incorporated the key recommendations from these reports into our work plans and services whilst managing an increasing difficult few years in terms of staffing and activity.

Following wide consultation around key priorities; action plans were developed by site, ward and department. These were captured by an organisational action plan progress of which has been reported to Board on a regular basis providing detail of actions and achievements.

Whilst a large amount of work has been undertaken which has resulted in significant changes to care delivery, some of the successes are as follows:

Staff experience & Leadership

- Restructure of the Senior Nursing Team
- New clinical leadership on Oak, Beech and Maple wards in Scarborough
- Increase of band 6 on Cherry to provide leadership every shift
- Introduction of Matron of the Day
- Introduction of Its My Ward for Band 6 nurses
- Introduction of Blue Thursday
- Introduction of 6monthly acuity and dependency audits
- Review of all budgets, establishments and ESR to ensure accurate staffing baseline

Patient Experience

- Implementation of the Friends and Family test across the Trust
- Knowing How We're Doing Boards are now displayed in wards and departments
- Partnership working with patient representative groups in our area, (particularly the three local Healthwatch teams, to ensure that patient voices are heard and that their views make a difference to the planning and delivery of our services.
- The introduction of above bed boards
- Integration of the Patient Advice and Liaison Service across York and Scarborough sites.
- Patient stories introduced in more high level meetings
- Development of support arrangement for patients with dementia leading to a new dementia strategy
- A new three year Patient Experience Strategy was launched in September 2015
- Patient Experience Team review resulting in team restructure

Patient Safety

- Launch of the Early Warning Trigger Tool (EWTT)
- Introduction of Advanced Clinical Practitioners
- Investment in Adult Safeguarding team
- Introduction of an electronic Falls assessment tool
- Pilot of the Infection Prevention and Control Ward Accreditation Tool
- The development of a revised enteral feeding protocol
- ACHILD & ABCD Child Protection Assessment Emergency Department trigger tools developed
- Child protection Medicals information leaflets have been developed
- The development of a Child Sexual Assault Assessment Centre covering North Yorkshire and York
- Increased focus on the Safeguarding Children Training
- Development of the Safeguarding Children's team
- Integration and streamlining practice and processes across York and Scarborough safeguarding teams
- Introduction of systems and processes for facilitate notification of Female Genital Mutilation cases
- Involvement in EPMA & roll out of new medicines trolleys across the Trust
- Introduction of Falls and Pressure Ulcer Panels to review and learn from all root cause analysis of incidents. (with a resultant reduction in falls and PU's)
- Highly successful recruitment campaign to attract newly qualified nurses

Within maternity services the following has been achieved:

- Introduction of extended visiting for partners of women who have recently given birth
- Maternity acuity tool completion
- Introduction of an on-call midwife for Labour ward
- Work on the reduction of stillbirths has commenced (around 50% reduction)
- The Babyclear project has now commenced to reduce smoking in pregnancy
- Breast Feeding Accreditation has been received
- Work commencing on the “sign up to safety” project to improve care of the perineum at birth
- Introduction of the Maternity EWTT in November 2015
- Introduction of the maternity dashboard enabling benchmarking against other units.
- Review of the midwifery preceptorship package
- Shortlisted for the Excellence in Maternity Care Award, RCM Midwifery Awards 2016.

The success is due to collaborative working with other teams across the organisation.

3. Nurse staffing

One of the key areas of the strategy was to ensure that wards have the right number of staff with appropriate skill mix to deliver safe, quality care for patients.

Nurse Staffing has presented one of the biggest challenges to the organisation in the last three years. This is due to a number of factors including organisational developments requiring additional staff, a national shortage of Registered Nurses, staff choosing the option ofearly retirement and non-elective activity & acuity of patients increasing year on year.

As a result; and linked to all key objectives of the N&M strategy a ‘Safer Staffing Project’ was introduced. This included a range of measures to support Matrons and Ward Sisters to manage staffing levels across all wards and units, increased reporting at Board level to provide assurance of safe levels, and also an intense focus on recruitment.
In addition a number of interventions were introduced to ensure safe staffing levels on a shift by shift basis.

These included:

- Introduction of daily staffing review meetings
- Examination of current staffing models on all wards
- Review of all RN levels in ward areas
- Increased non registered workforce overnight
- Introduced additional RNs in community sites
- Block booking of nursing staff through bank and agencies to ensure continuity of care
- Introduction of relocation packages for Band 7 and above
- Introduction of the Band 3 Senior Healthcare Assistant role
- Local Contracts for family friendly working
- Professional Judgement Review of staffing levels
- Reviewing and developing the escalation processes
- Improved workforce reporting and monitoring through the introduction of the Nursing Dashboard
- Increased and improved nursing recruitment campaigns and initiatives
- Enhanced pay initiatives for Trust staff working on the Nurse Bank
- Introduction of generic RN recruitment

In addition; and following the success of the Scarborough Nurse Bank a Trust a York site Nurse Bank was introduced on 1st April 2016, and a European nurse recruitment campaign commenced in October 2015.

4. Nursing Recruitment Initiatives

In March 2015, the Trust embarked on a bespoke centralised campaign to attract final year Nursing Students through attendance at university careers fairs and local advertising. This was a highly successful campaign for the Trust and the highest cohort of newly qualified nurses to be appointed to one organisation in the Yorkshire and Humber region. We will look to build on this success in the 2016 campaign.

Since April 2015 372 advertisements were placed for Registered Nurse roles, this led to 169 appointments being made.

In November 2015 following the success of the newly qualified nurse campaign, generic RN interviews were introduced providing a central gateway in applying for RN posts into the organisation. Interviews are co-ordinated and successful candidates are matched to vacancies with their preferred clinical area and location. To date 35 registered nurses are currently being recruited into the organisation.

In late September 2015 we began a European recruitment campaign. Advertisements' were placed through a recruitment agent in Spain, Portugal, Italy, Greece, Czech Republic, Poland and Croatia. In October Skype interviews commenced and the first cohort of 6 nurses began work in December 2015. A further 11 are commenced on 11th January 2016 and at least 13 more nurses have start dates to begin on 25th January 2016. More interviews are scheduled to take place in mid-January and during February 2016.

During 2015, 163 Healthcare Assistants were appointed to the Trust. All of these HCAs have attended an induction programme and are undertaking their National Care Certificate and subsequent NVQ Level 2 in Fundamental Care Delivery in Acute Settings.

In March 2015, the Trust introduced the role of the Band 3 Senior Healthcare Assistant, this is to provide a more senior and experienced non registered nursing role. These were introduced in areas such as AMU across York and Scarborough Hospital sites to support the assessment and delivery of care to patients, 18 people were appointed to these posts and a further recruitment campaign is scheduled for early 2016. In addition, 4 Healthcare Assistants have been successful in obtaining sponsored Open University places to train as Registered Nurses over the next three years.

During 2016, we intend to remain focused on our recruitment initiatives, continuing to develop links with the University Schools of Nursing, attending recruitment fairs and making York Trust an employer of choice for registered and non registered nursing staff.

5. Nursing Dashboards and Early Warning Trigger Tool

One of the objectives of the N&M Strategy was to report the quality of care delivered at ward level in a meaningful way. Historically we used Nursing Care Indicators' which were based upon a point prevalence audit of nursing assessments undertaken monthly. An early warning trigger tool was introduced in November 2014 to report on ward level quality and safety indicators. These have a RAG rating and flag any areas that are at risk, any areas rated RED are required to present an action plan to be monitored regularly by the ADN for the relevant site and submitted to the Executive Nursing Forum for assurance.

In addition, since June 2015 the Chief Nurse Team has been compiling a nursing dashboard for each of the inpatient wards and units across the Trust. The dashboard captures the most recent workforce metrics, patient safety indicators, infection prevention statistics and, at present; EWTT data to enable more effective monitoring and management of the wards.

The intention of the dashboards is to provide an overview of the key performance indicators for the wards and it is anticipated that these will evolve over time as new priorities emerge.

Consideration is currently being given to these nursing dashboards replacing the current EWTT reporting system to avoid duplication as many of the metrics can now be obtained and accurately collated from systems such as ESR, Signal and, Datix. These dashboards will now be used in the new performance management meetings and will be presented to the Board of Directors periodically (and on an exception basis where risks exist) to focus on risk and mitigations.

Trust wide dashboards broken down to site are compiled monthly and these will be presented each month as appendices in future Chief Nurse Reports, an example is attached at appendix 2.

6. Summary and recommendation

The Trust is now in the final months of its current Nursing & Midwifery strategy for 2013-16 and this report illustrates the significant progress which has been made towards its achievement. Work is now underway to identify the key priorities for the next 3 years and this will be presented to the Board in the coming months.

7. References

- The Francis Report - Inquiry into Mid Staffordshire NHS Foundation Trust (2013)
- Hard Truths – The Journey to Putting Patient First (Department of Health (2014)
- “How to ensure the right people, with the right skills, are in the right place at the right time” the National Quality Board (2013)
- The CQC Essential Standards, Care Quality Commission

Author	**Beverley Geary, Chief Nurse**
Owner	**Beverley Geary, Chief Nurse**
Date	**January 2016**

Appendix 1

Findings from Audit Report, August 2015

Opinion: Significant Assurance

Control Objective	Assurance Level	Number of Recommendations		
		High	Medium	Low
1	Significant	0	0	0
2	Significant	0	1	1
3	Significant	0	0	1
Total	Significant	0	1	2

Control Objectives

1. The Nursing and Midwifery Strategy aligns with the Trust values and strategic objectives.
2. Progress is made towards delivering the key priorities within the Strategy.
3. Adequate governance arrangements are in place to monitor the delivery of the Strategy.

Areas of Good Practice

- The Chief Nurse has Board level responsibility for the implementation of the Nursing and Midwifery Strategy.
- The Strategy aligns with the Trust's values and strategic objectives.
- Regular progress updates are provided to the Quality and Safety Committee and the Board of Directors.
- An Implementation Plan has been devised to support delivery of the Strategy.

Nursing Dashboard - Bridlington

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cummtotal	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				0	1	0	0	0	0	1	2	2
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	1	1
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				0	1	0	0	0	0	0	1	1
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	1	0	0
		Deep Tissue Injury						0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				1	3	11	0	2	3	0	1	0
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				0	0	0	0	0	0	0	0	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			94.44	90.00	91.30	90.48	90.91	91.84	95.65	92.45	91.49
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				1.00	0.00	3.00	1.00	0.00	1	1	1	1
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				1.00	1.00	0.00	1.00	0.00	2	0	0	0
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0.00	1.00	1.00	0.00	0.00	0	0	0	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0.00	0.00	1.00	0.00	0.00	0	0	0	0
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0.00	0.00	0.00	0.00	0.00	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				8.59	10.76	5.74	7.38	8.18	5.4	5.72	3.72	5.08
		Inpatient area vacancies - HCA	Number	CN Team				0.00	1.68	1.00	1.42	2.06	-0.2	0.08	0.08	1.68
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				6.25%	6.67%	8.70%	3.16%	11.39%	8.05%	6.06%	6.36%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			90.10%	87.20	100.70	96.80	90.20	89	89.8	94.7	86.9
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			108.40%	104.30	84.30	95.50	79.80	75.8	73.9	93.2	90.7
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			80.20%	79.00	95.60	81.40	85.80	82.3	85.2	73.8	67.9
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			126.90%	135.20	129.50	121.30	121.50	106.4	112.7	145	166.1
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info					48.00%	56.30%	70.70%	49.24%	61.40%	82.80%	83.50%	70.95%
	Agency Fill Rate	Fill Rate	%	Workforce Info					26.50%	26.80%	20.20%	37.39%	19.50%	6.50%	7.78%	3.39%
Infection Prevention	MRSA	MRSA Bacteraemia	Accumulated number of patients	IC Team	0	Green	3	1	2	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%			90.11	89.67	92.83	88.00	90.55	93.33	94.06	91.1	90.78
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			0.00	33.33	83.33	100.00	88.89	66.67	100	83.33	100
	C.Difficile	C DIF Toxin Trust Attributed	Accumulated number of patients	IC Team	48	Green	3	0	0	1	0	1	0	1	0	0
	MSSA	MSSA Bacteraemia	Accumulated number of patients	IC Team	<30	Red	0	0	0	0	0	0	0	0	0	0
	E-Coli	E-Coli Bacteraemia	Accumulated number of patients	IC Team			2	0	0	1	0	0	0	1	0	0
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	95%	Amber		90.00%	59.00%	68.00%	86.17%	82.50%	74.28%	83.33%	92.50%	90.28%
	Matron Environmental Audits	Enivironmental Audits	Compliance %	IC Team	95%			93.00%	93.00%	95.67%	96.20%	95.50%	98.00%	98.00%	98.50%	96.00%
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - healthcare governance				0	0	1	0	0	0	0	0	0
	Critical Incidents	CI's reported	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0
	Never Events	Never Events declared	Number	Datix - healthcare governance				0	0	0	0	0	0	0	0	0
	Friends and Family	Inpatient Friends and Family Test	%Recommend	Signal				97.51%	99.65%	97.25%	98.21%	98.71%	98.16%	98.39%	100.00%	not yet available
			%Not Recommend	Signal				1.42%	0.00%	1.37%	0.36%	0.32%	0.61%	0.81%	0.00%	not yet available
		A&E Friends and Family Test	% Recommend	Signal				--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--
		Maternity (Ante Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--
		Birth	% Recommend	Signal				--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--
		Maternity (Post Natal)	% Recommend	Signal				--	--	--	--	--	--	--	--	--
			% Not Recommend	Signal				--	--	--	--	--	--	--	--	--
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				2	1	1	0	0	0	1	*	*
		Staff Attitude	Number	PE Team				0	0	1	0	0	0	0	*	*
		Patient Care	Number	PE Team				2	1	0	0	0	0	0	*	*
		Communication	Number	PE Team				0	0	0	0	0	0	0	*	*

Nursing Dashboard - Scarborough

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trust Trajectory	Cum Total	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU			4	1	4	3	4	4	1	3	5
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU			1	0	0	0	1	0	0	0	0
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU			3	1	2	2	2	2	1	3	3
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	2	1	1	2	0	0	2
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU			0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS			8	5	2	1	2	4	8	8	8
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS			1	0	0	0	0	0	0	2	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%		91.26	92.64	94.77	90.80	90.68	93.89	93.08	91.04	90.2
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS			8	9	5	11	7	8	11	10	11
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS			9	3	3	7	10	3	2	4	7
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			0	0	0	1	1	0	0	1	0
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			1	1	0	1	0	1	1	1	1
	VTE Other	VTE Other	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE			1	1	0	1	0	0	0	0	1
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team			33.04	24.91	20.30	28.20	25.45	31.15	30.57	36.66	26.93
		Inpatient area vacancies - HCA	Number	CN Team			10.25	11.90	5.83	0.00	3.98	-8.56	-6.86	-11.24	-3.69
	Sickness	Sickness (In Patient Areas)	%	Workforce Info			3.57%	5.55%	4.58%	5.15%	4.98%	5.16%	4.61%	5.08%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%		81.30%	76.20%	85.70%	86.80%	81.50	80.5	81.7	83.8	87.5
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%		94.30%	92.50%	93.30%	93.50%	90.00	89.8	92.3	104.6	102.5
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%		99.30%	95.00%	109.80%	112.00%	113.20	109.4	109.2	94.1	90.8
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%		119.50%	117.60%	120.20%	115.40%	119.50	105.9	108.8	108.4	108.8
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info				45.70%	52.60%	51.00%	48.64%	51.80%	59.40%	62.00%	57.17%
	Agency Fill Rate	Fill Rate	%	Workforce Info				28.00%	30.00%	33.30%	27.72%	22.70%	19.40%	18.70%	14.63%
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0	3	0	1	2	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%		78.22	87.01	84.42	91.18	95.31	88.89	95.92	92.36	74.38
		MRSA Screening - Non-Elective	Compliance %	Signal	95%		85.66	86.56	84.30	89.44	89.93	85.76	90.32	91.55	86.69
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	48	14	0	6	3	2	0	1	0	0	2
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	<30	12	1	3	1	1	0	2	1	2	1
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team		28	2	6	3	3	0	4	3	4	3
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	95%		85.00%	86.00%	91.00%	92.00%	92.00%	98.05%	93.65%	95.26%	93.20%
	Matron Environmental Audits	Enivironmental Audits	Compliance %	IC Team	95%		94.00%	95.00%	95.46%	94.00%	86.00%	91.00%	95.68%	97.00%	93.50%
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance			1	5	3	6	2	4	4	6	4
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance			2	2	1	5	1	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Governance			0	0	0	0	0	0	0	0	0
Patient Experience	Friends and Family Test	Inpatient Friends and Family Test	%Recommend	Signal			96.81	96.07	94.78	95.74	95.02	96.61	97.81	95.00	not yet available
			%Not Recommend	Signal			0.87	1.59	0.26	1.26	1.39	0.85	0.40	1.00	not yet available
		A&E Friends and Family Test	% Recommend	Signal			78.98	75.14	82.31	79.76	80.12	79.31	71.83	85.10	not yet available
			% Not Recommend	Signal			15.92	19.77	9.52	13.69	16.27	13.79	19.72	9.20	not yet available
		Maternity (Ante Natal)	% Recommend	Signal			100	23.46	21.82	95.34	21.18	98.00	100.00	100.00	not yet available
			% Not Recommend	Signal			0	0.60	0.00	0.00	0.00	0.00	0.00	0.00	not yet available
		Birth	% Recommend	Signal			97.4	34.78	38.80	96.00	93.75	100.00	100.00	100.00	not yet available
			% Not Recommend	Signal			0	1.74	0.00	0.00	2.00	0.00	0.00	0.00	not yet available
		Maternity (Post Natal)	% Recommend	Signal			94.4	22.70	20.10	100.00	100.00	100.00	96.20	100.00	not yet available
			% Not Recommend	Signal			0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	not yet available
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team			11	7	1	11	3	11	13	*	*
		Staff Attitude	Number	PE Team			1	1	0	2	1	3	0	*	*
		Patient Care	Number	PE Team			9	4	1	5	1	4	2	*	*
		Communication	Number	PE Team			1	2	0	4	1	4	5	*	*

Nursing Dashboard - York

York Teaching Hospital NHS
NHS Foundation Trust

		Metric	Measure	Data Source	Trajectory	RAG	Cum.Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Patient Safety	Pressure Ulcers	PURP Overall	No. of Patients (PP)	Safety Thermometer - NEW PU				9	3	2	3	1	2	3	1	8
		Cat 4	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	1	0	0
		Cat 3	No. of Patients (PP)	Safety Thermometer - NEW PU				1	1	0	0	0	0	0	0	1
		Cat 2	No. of Patients (PP)	Safety Thermometer - NEW PU				6	2	2	2	1	2	0	1	5
		Unstageable	No. of Patients (PP)	Safety Thermometer - NEW PU				2	0	0	1	0	0	2	0	2
		Deep Tissue Injury	No. of Patients (PP)	Safety Thermometer - NEW PU				0	0	0	0	0	0	0	0	0
	Falls	Falls	No. of Patients (PP)	Safety Thermometer - FALLS				23	14	10	11	18	18	15	18	23
		Falls With Harm (Moderate/Severe)	No. of Patients (PP)	Safety Thermometer - FALLS				2	0	1	0	0	0	1	2	0
	Safety Thermometer	Safety Thermometer Overall (Harm Free Care)	%	Safety Thermometer - CQUIN HARM FREE %	95%			94.58	94.26	94.33	95.03	95.83	95.1	95.22%	96.09%	92.73
	Catheter acquired UTI	New UTI	No. of Patients (PP)	Safety Thermometer - CQUIN HARMS				5	10	9	8	7	11	3	7	11
	Critical Missed Meds	Critical Missed Meds	No. of Patients (PP)	Safety Thermometer - OMITTED CRITICAL MEDS				7	9	4	8	1	9	6	6	3
	Deep Vein Thrombosis	New DVT	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				0	2	1	1	0	1	3	2	3
	Pulmonary Embolism	New PE	No. of Patients (PP)	Safety Thermometer - VTE TREATMENT TYPE				2	3	1	0	0	0	1	0	2
	VTE Other	VTE Other		Safety Thermometer - VTE TREATMENT TYPE				0	0	0	0	0	0	0	0	0
Workforce	Vacancies	Inpatient area vacancies -RN	Number	CN Team				42.82	47.63	33.82	42.64	64.20	81.66	53.78	42.13	64.31
		Inpatient area vacancies - HCA	Number	CN Team				12.04	4.88	5.08	10.53	13.66	24.43	23.29	-0.18	10.05
	Sickness	Sickness (In Patient Areas)	%	Workforce Info				2.92%	3.70%	3.28%	2.56%	3.11%	3.43%	4.47%	3.96%	
	Safer Staffing Return	Qualified Fill Rated - Day	%	Safer Staffing Return	Between 80 - 100%			88.40%	85.00	88.90	90.80	87.60	85.4	85.8	90.3	88
		Qualified Fill Rated - Night	%	Safer Staffing Return	Between 80 - 100%			110.00%	108.90	97.00	95.60	93.70	94.3	94.3	96.6	94.5
		Unqualified Fill Rates - Day	%	Safer Staffing Return	Between 80 - 100%			96.60%	104.30	119.50	116.30	104.90	99.5	100	95.4	93.6
		Unqualified Fill Rates - Night	%	Safer Staffing Return	Between 80 - 100%			106.50%	116.40	119.70	120.10	109.00	106.7	109.1	108.5	103.1
	Internal Bank Fill Rate	Fill Rate	%	Workforce Info					25.90	27.70	25.90	28.62	29.2	27.94	31.9	32.55
	Agency Fill Rate	Fill Rate	%	Workforce Info					52.40	57.00	62.70	53.11	44.9	43.31	43.1	36.69
Infection Prevention	MRSA	MRSA Bacteraemia	Cummulative	IC Team	0		1	1	0	0	0	0	0	0	0	0
		MRSA Screening - Elective	Compliance %	Signal	95%			95.90%	97.03%	96.71%	95.10%	97.00%	97.20%	96.61%	97.85%	94.63%
		MRSA Screening - Non-Elective	Compliance %	Signal	95%			73.46%	74.89%	77.19%	76.36%	78.67%	78.21%	74.49%	79.69%	76.26%
	C.Difficile	C DIF Toxin Trust Attributed	Cummulative	IC Team	59		28	7	2	2	0	3	2	4	3	5
	MSSA	MSSA Bacteraemia	Cummulative	IC Team	29		16	2	2	2	3	0	1	5	0	1
	E-Coli	E-Coli Bacteraemia	Cummulative	IC Team			30	6	2	4	1	4	2	3	4	4
	Hand Hygiene	Hand Hygiene Compliance 95%	Compliance %	IC Team	95%		9	93.00%	95.00%	97.00%	98.00%	96.00%	96.00%	97.00%	94.00%	96.00%
	Matron Environmental Audits	Enivironmental Audits	Compliance %	IC Team	95%		9	98.00%	98.00%	98.00%	92.00%	97.00%	95.00%	95.00%	96.00%	96.00%
Risk Management (Trust wide)	Serious Incidents	SI's declared	Number	Datix - Healthcare Governance				0	4	9	10	4	6	13	9	5
	Critical Incidents	CI's reported	Number	Datix - Healthcare Governance				2	2	1	4	6	0	0	0	0
	Never Events	Never Events declared	Number	Datix - Healthcare Governance				0	0	1	0	0	0	0	0	0
Patient Experience	Friends and Family	Inpatient Friends & Family Test	%Recommend	Signal				95.17	96.26	95.95	95.84	97.53	95.98	96.25	94.96	not available yet
			%Not Recommend	Signal				2.24	1.13	1.79	0.93	0.75	1.00	1.12	1.60	not available yet
		A&E Friends and Family Test	% Recommend	Signal				79.81	82.42	82.06	86.76	86.84	82.20	79.35	74.50	not available yet
			% Not Recommend	Signal				14.42	12.53	12.92	8.06	8.92	12.43	12.83	18.30	not available yet
		Maternity (Ante Natal)	% Recommend	Signal				100.00	85.00	95.18	97.67	93.93	95.24	86.79	100.00	not available yet
			% Not Recommend	Signal				0.00	15.00	0.00	0.00	0.00	3.17	1.89	0.00	not available yet
		Birth	% Recommend	Signal				94.18	21.20	21.10	96.00	96.00	98.50	95.50	91.67	not available yet
			% Not Recommend	Signal				0.00	0.00	0.00	0.00	0.00	0.00	0.90	8.30	not available yet
		Maternity (Post Natal)	% Recommend	Signal				--	15.18	20.08	100.00	100.00	97.06	95.60	100.00	not available yet
			% Not Recommend	Signal				--	0.40	0.00	0.00	0.00	1.47	1.09	0.00	not available yet
	Complaints *new DATIX system reporting not yet available. Will be populated asap.	Complaints Total	Number	PE Team				9	17	10	6	5	8	24	*	*
		Staff Attitude	Number	PE Team				0	0	1	1	1	3	2	*	*
		Patient Care	Number	PE Team				3	9	5	2	2	2	4	*	*
		Communication	Number	PE Team				6	8	4	3	2	3	5	*	*

Blank page

D4

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 27 January 2016

Safe Nurse and Midwifery Staffing Report

Action requested/recommendation

The Board of Directors is asked to receive the exception report for information.

Summary

The Board of Directors are aware that from May 2014 all organisations were required to report actual versus planned nurse staffing levels. This is the twentieth submission to NHS choices of actual against planned staffing data for day and night duty in hours and by ward.

A detailed breakdown for December 2015 staffing levels is attached at Appendix 1.

The data from this report continues to be produced from the revised tool which was introduced in June 2015.

In addition this report contains additional information on annual attrition rates, bank and agency use and fill rates.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Reference to CQC outcomes

Outcome 13

Progress of report	Quality and Safety Board of Directors
Risk	Relevant risks identified in the report.
Resource implications	Potential resources implications where staffing falls below planned or where acuity or dependency increases due to case mix.
Owner	Beverley Geary, Chief Nurse
Author	Nichola Greenwood, Nursing Workforce Projects Manager
Date of paper	January 2016
Version number	Version 1

Board of Directors - 27 January 2016

Safe Nurse and Midwifery Staffing Report

1. Introduction

The Board of Directors are aware that from May 2014 all organisations were required to report actual versus planned nurse staffing levels. This is the twentieth submission to NHS choices of actual against planned staffing data for day and night duty in hours and by ward.

A detailed breakdown for December 2015 staffing levels is attached at Appendix 1.

The data from this report continues to be produced from the revised tool which was introduced in June 2015.

In addition this report contains additional information on annual attrition rates, bank and agency use and fill rates.

2. High level data by site

	Day		Night	
Site Name	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**
Archways Intermediate Care Unit	98.4%	83.2%	103.2%	95.2%
Bridlington And District Hospital	86.9%	90.7%	67.9%	166.1%
Malton Community Hospital	84.5%	108.3%	101.6%	98.4%
Scarborough General Hospital	87.5%	102.5%	90.8%	108.8%
Selby And District War Memorial Hospital	92.9%	98.7%	59.7%	180.6%
St Helens Rehabilitation Hospital	95.2%	86.5%	88.7%	100.0%
Whitby Community Hospital	95.3%	91.7%	100.0%	100.0%
St Monica's Hospital	87.1%	85.6%	98.4%	90.3%
White Cross Rehabilitation Hospital	96.0%	95.5%	85.5%	100.0%
York Hospital	88.0%	94.5%	93.6%	103.1%

3. Exceptions

Enhanced Supervision

A number of areas show an over 100% fill rate – usually in care staff. This is due to the enhanced supervision patients who require a higher level of observations. These areas were:

Bridlington	Scarborough	York	
Johnson	Ann Wright	AMU	Ward 32
	Maple	Ward 33	Ward 34
	Oak	Ward 35	Ward 36
		Ward 29	

Provision of Safe Ward Cover

The Matrons are responsible for ensuring staffing levels are as safe as possible throughout the day and night. This means that staffing is assessed throughout the day and for out of hours and weekends and effective and safe plans are implemented. This does result in staff moving from their base wards on occasions and where necessary, increase Healthcare Assistant provision to support the shortfall of registered nurses or vice versa. These wards were:

Bridlington	Scarborough		Community	York
Johnson	Ann Wright	Beech	Fitzwilliam	AMU
Waters	Cherry (AMU)	CCU	Selby	Ward 15
	Chestnut	Holly		Ward 16
	Maple	Oak		Ward 23
	Stroke			Ward 26
				Ward 28
				Ward 35

Bed Occupancy

Lloyd and Kent Wards at Bridlington and War Memorial Ward at Whitby changed their ratio of registered and unregistered staff dependent on bed occupancy levels and the effective use of staff with staff being deployed to other ward areas. G2 and G3 share a healthcare assistant and during August, the healthcare assistant was predominantly on G2, which increased its staffing levels.

Ward 29 has also provided some support to other wards when the ward was closed ward due to infection during the month.

Activity demands on some wards have resulted in the ESA in York remaining open some nights; resulting in increased actual staffing.

The Surgical Assessment Unit on Lilac ward remained open longer than usual during December to help manage activity. This resulted in a higher level of staffing.

ESA at York was closed throughout the Christmas bank holiday 4 day weekend

Vacancies, Sickness and Annual Leave

The Trust's ability to fill shifts due to sickness and vacancies reduce the average percentage staffing levels each month. At the end of December 2015 there was also the well publicised and unprecedented rainfall in York which led to a small number of staff being unable to leave their homes and attend work due to flooding.

The wards detailed overleaf have reported reduced actual staffing for these reasons:

Bridlington	Community	Scarborough		York	
Lloyd	Archways	Ann Wright	Beech	AMU	G2
	Selby	Cherry	CCU	G3	ICU
	Whitecross Court	Chestnut	Holly	Ward 15	Ward 16
		Oak		Ward 23	Ward 26
				Ward 32	Ward 33
				Ward 35	Ward 36
				Ward 37	Ward 39

Actions and Mitigation of risk
Daily staffing meetings are taking place to deploy staff to high risk areas.

4. Vacancies by Site

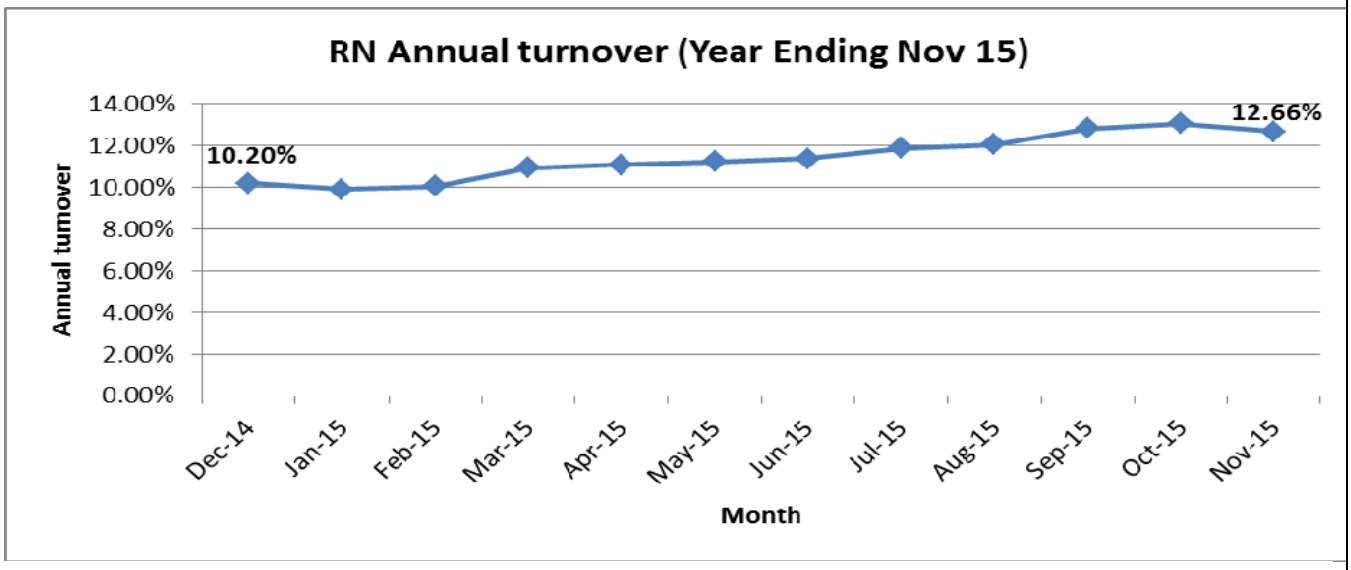
The vacancy information for the adult inpatient areas below, has been taken from the ward budgeted establishments from the finance ledger and the staff in post data from ESR as at the end of December 2015. The vacancies pending start has been collated from central records following the introduction of centralised recruitment in HR.

	Reported vacancies		Vacancies filled pending start		Unfilled Vacancies	
	RN	**HCA**	**RN**	**HCA**	**RN**	**HCA**
Bridlington	7.08	1.68	2	0	5.08	1.68
Community	15.35	4.37	5	0.6	10.35	3.77
Scarborough	37.93	1.35	11	5.04	26.93	-3.69
York	98.51	23.65	34.20	13.6	64.31	10.05
Total	**158.87**	**31.05**	**52.2**	**19.24**	**106.67**	**11.81**

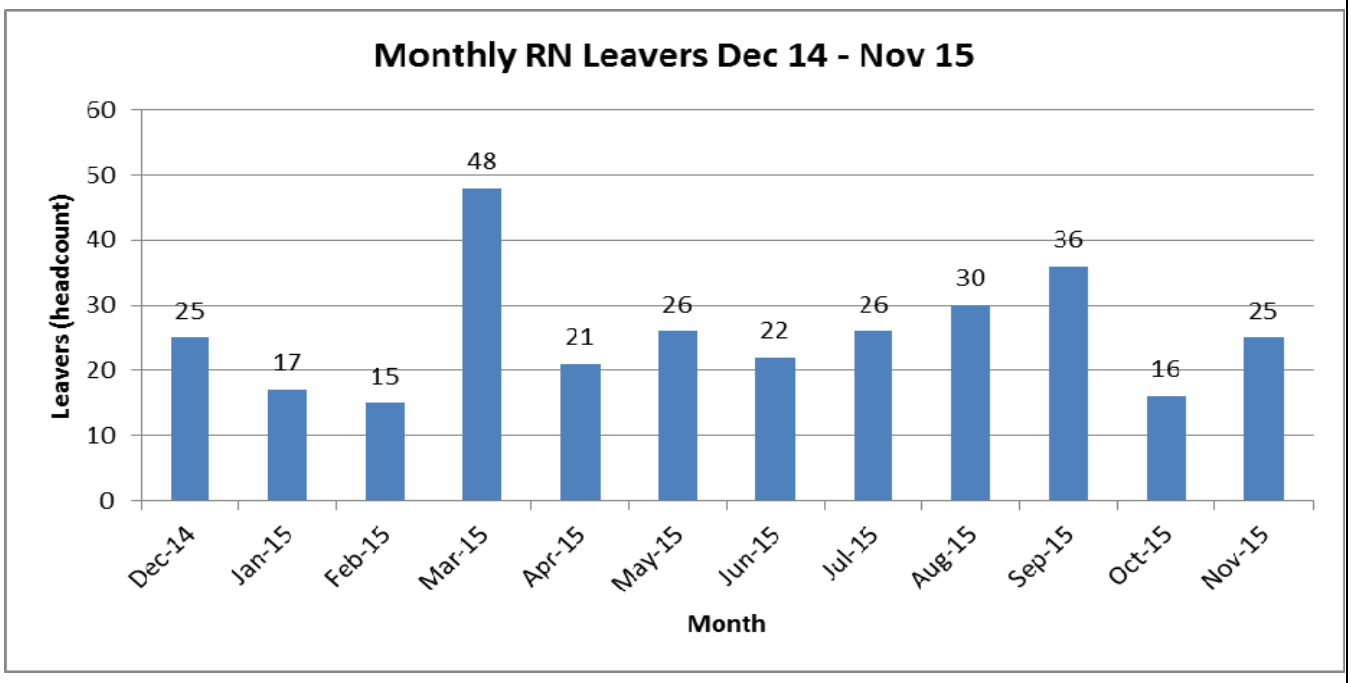
Of the 52.5wte vacancies pending start, this includes 29.2 individuals who have been recruited through local generic recruitment and a further 23 individuals who have been recruited through the European recruitment campaign.

5. Staffing Levels

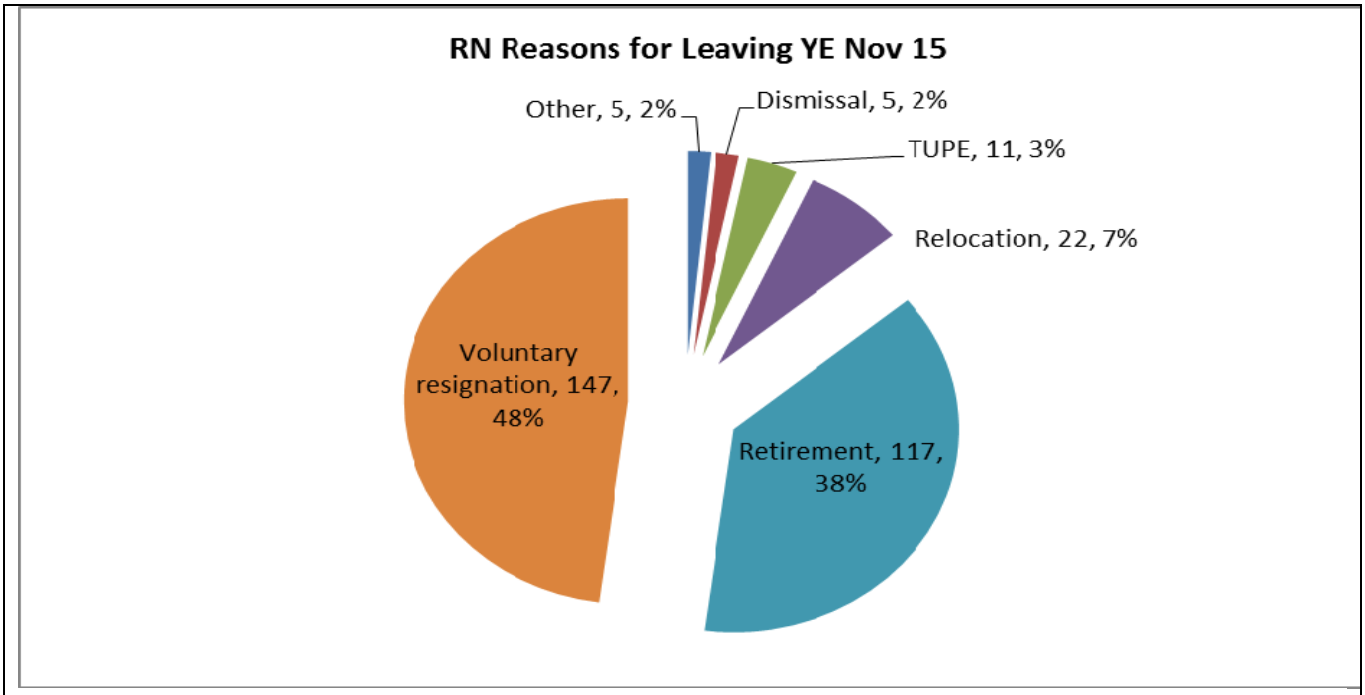
Registered nursing turnover is increasing with the end of November 2015 turnover will rate being 12.66%. The graph overleaf provides the last twelve months turnover rate.



In the last twelve months, the number of RN leavers has fluctuated with a month on month increase between April 2015 to September 2015, this is due to a number of factors; however we have seen as significant increase in the numbers of Registered Nurses taking early retirement. The chart bellows shows the month on month position. The data for the March 2015 include staff who were transferred out of the organisation under TUPE arrangements.



The documented reasons for leaving; captured through leaver forms shows that retirement accounts for 38% of leavers with a further 48% leaving voluntarily to seek employment elsewhere. The Nursing and Midwifery recruitment, retention and reporting group is exploring ways to better understand the reasons why nurses are choosing the leave the Trust and ways to improve nurse retention across all our sites.



Bank and Agency use.
In order to mitigate risks and ensure safe staffing levels. We commonly use temporary workforce, as the Committee are aware; following the success of the nurse bank which has existed in Scarborough, the York site introduced its own Nurse Bank in April 2015. Historically temporary workforce was provided by NHSP.

In York the average fill rate for temporary staffing this financial year to date is 78.49%, of which 50.20% was filled through agencies with 28.29% through the nursing bank. The total hours filled through bank and agency in York was 226,645 hours. We are currently working to increase recruitment to our internal bank and have recently introduced a number of incentives including enhanced pay rates. (This happened I, November 2015, early indications show an increase in the number of nurses requesting to join this bank.)

In Scarborough & Bridlington, the average fill rate was 81.75%, of which 29.35% was filled through agencies and 52.40% through the nursing bank. The total hours filled through bank and agency in Scarborough was 212,542 hours.

Monitor introduced new rules on the use of agency staff in September 2015. This is an attempt to reduce agency spend across the NHS and to reduce reliance on temporary workforce. The rules included the requirement that only 'framework' agencies can be used without specific approval from Monitor. In line with these rules we are continuing to closely monitor temporary staffing and reasons for agency usage and as required; report all off Framework use (with reasons) to Monitor on a weekly basis.

The graph below provides the summary of overall Trust bank and agency hours for registered nurses and healthcare assistants filled during this financial year.

Month	Requested (Hours)	Bank Filled (Hours)	% Bank Filled	Agency Filled (Hours)	% Agency Filled	Overall Fill Rate (%)	Unfilled (Hours)	% Unfilled
April 2015	44,155	16,120	36.51%	16,789	38.02%	74.53%	11,246	25.47%
May 2015	52,833	17,659	33.42%	23,113	43.75%	77.17%	12,061	22.83%
June 2015	48,624	17,370	35.72%	22,618	46.52%	82.24%	8,636	17.76%
July 2015	51,617	18,539	35.92%	26,562	51.46%	87.38%	6,516	12.62%
August 2015	48,732	18,096	37.13%	21,029	43.15%	80.29%	9,607	19.71%
September 2015	46,654	17,957	38.49%	16,572	35.52%	74.01%	12,125	25.99%
October 2015	48,072	18,162	47.15%	17,216	30.40%	77.55%	12,697	22.45%
November 2015	47,197	20,810	44.09%	15,551	32.95%	77.04%	10,836	22.96%
Total:	**387,884**	**144,714**	**37.31%**	**159,450**	**41.11%**	**78.42%**	**83,723**	**21.58%**

Each month the Board receives data on the nursing and midwifery staffing levels. In June 2015, the Trust changed the way it captured this information to reflect the different ways each ward operated its shifts and to move away from bed occupancy being used as a method of calculation.

The chart below provides the Trust average level of staffing during this financial year to date.

	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015
Qualified Fill Rated - Day	100.03 %	94.85%	93.39%	93.95%	91.31%	91.70%	92.80%	92.00%
Qualified Fill Rated - Night	113.16 %	108.27 %	95.96%	95.93%	96.67%	88.60%	93.50%	95.40%
Unqualified Fill Rates - Day	93.69%	93.07%	103.03 %	100.85 %	100.10 %	98.50%	96.70%	100.70 %
Unqualified Fill Rates - Night	105.22 %	107.02 %	107.16 %	105.51 %	104.03 %	100.60 %	109.30 %	104.50 %

6. Recommendation

The Board of Directors is asked to receive the exception report for information.

7. References and further reading
National Quality Board. "*How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability".* 2013

Author	**Nichola Greenwood, Nursing Workforce Projects Manager**
Owner	**Beverley Geary, Chief Nurse**
Date	**January 2016**

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RCB
Period: December_2015-16

#REF!

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

http://www.yorkhospitals.nhs.uk/about_us/reports_and_publications/safer_staffing_data/

Comments

#REF! #REF! #REF!

Only complete sites your organisation is accountable for

Hospital Site Details			Main 2 Specialties on each ward		Day				Night				Day		Night	
					Registered		Care Staff		Registered		Care Staff					
Site code (The Site code is automatically populated when a Site name is selected)	Hospital Site name	Ward name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ann Wright	430 - GERIATRIC MEDICINE		1116	859	930	1272	682	682	341	561	76.9%	136.8%	100.0%	164.5%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Ash	100 - GENERAL SURGERY		930	907.5	930	915	682	605	0	88	97.6%	98.4%	88.7%	-
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Beech	300 - GENERAL MEDICINE		1488	1434	1302	1332	1023	980	682	682	96.4%	102.3%	96.0%	100.0%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Cherry	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1860	1620	1488	1524	1705	1397	1364	1276	87.1%	102.4%	81.9%	93.5%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Chestnut	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1488	1170	1116	1110	682	682	682	704	78.6%	99.5%	100.0%	103.2%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Coronary Care Unit	320 - CARDIOLOGY		2325	2032.5	465	765	1364	1155	341	484	87.4%	164.5%	84.7%	141.9%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Duke of Kent	420 - PAEDIATRICS		1627.5	1492.5	465	435	682	682	341	341	91.7%	93.5%	100.0%	100.0%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Hawthorn	501 - OBSTETRICS		744	744	372	372	682	682	0	0	100.0%	100.0%	100.0%	-
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Holly	110 - TRAUMA & ORTHOPAEDICS		1116	954	1116	1218	682	682	682	649	85.5%	109.1%	100.0%	95.2%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Intensive Therapy Unit	192 - CRITICAL CARE MEDICINE		2790	2287.5	465	165	1705	1606	0	0	82.0%	35.5%	94.2%	-
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Lilac	101 - UROLOGY	100 - GENERAL SURGERY	1860	1612.5	1860	1552.5	682	814	682	726	86.7%	83.5%	119.4%	106.5%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Maple	100 - GENERAL SURGERY		2325	2115	1162.5	1485	1364	1155	682	836	91.0%	127.7%	84.7%	122.6%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Oak	430 - GERIATRIC MEDICINE		1674	1440	1860	1752	1023	902	1023	1045	86.0%	94.2%	88.2%	102.2%
	SCARBOROUGH GENERAL HOSPITAL - RCBCA	Stroke	430 - GERIATRIC MEDICINE		1116	990	744	738	1023	770	341	396	88.7%	99.2%	75.3%	116.1%
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Johnson	430 - GERIATRIC MEDICINE		930	870	1302	1422	682	649	341	473	93.5%	109.2%	95.2%	138.7%
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Kent	110 - TRAUMA & ORTHOPAEDICS		1162.5	907.5	930	810	682	319	0	275	78.1%	87.1%	46.8%	-
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Lloyd	100 - GENERAL SURGERY		690	577.5	690	202.5	418	132	0	0	83.7%	29.3%	31.6%	-
	BRIDLINGTON AND DISTRICT HOSPITAL - RCBNH	Waters	430 - GERIATRIC MEDICINE		930	870	930	1057.5	682	572	341	385	93.5%	113.7%	83.9%	112.9%
	YORK HOSPITAL - RCB55	11	100 - GENERAL SURGERY	101 - UROLOGY	1519	1440	912	840	682	682	682	682	94.9%	92.1%	100.0%	100.0%
	YORK HOSPITAL - RCB55	14	100 - GENERAL SURGERY	101 - UROLOGY	1674	1614	1116	930	1023	1012	682	649	96.4%	83.3%	98.9%	95.2%
	YORK HOSPITAL - RCB55	15	120 - ENT	101 - UROLOGY	1860	1805	1395	1402.5	1023	957	341	341	96.3%	100.5%	93.5%	100.0%
	YORK HOSPITAL - RCB55	16	100 - GENERAL SURGERY		2437.5	2362.5	1042.5	1050	1364	1331	682	660	96.9%	100.7%	97.6%	96.8%
	YORK HOSPITAL - RCB55	17	420 - PAEDIATRICS		1488	1398	372	234	1023	1001	341	308	94.0%	62.9%	97.8%	90.3%
	YORK HOSPITAL - RCB55	23	430 - GERIATRIC MEDICINE		1627.5	1425	1395	1560	682	682	1023	979	87.6%	111.8%	100.0%	95.7%
	YORK HOSPITAL - RCB55	25	430 - GERIATRIC MEDICINE		1488	1148	930	1110	682	682	1023	990	77.0%	119.4%	100.0%	96.8%

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered		Care Staff		Registered		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
	YORK HOSPITAL - RCB55	26	430 - GERIATRIC MEDICINE		1627.5	1462.5	1395	1477.5	682	682	1023	1012	91.7%	105.9%	100.0%	98.9%
	YORK HOSPITAL - RCB55	28	110 - TRAUMA & ORTHOPAEDICS		1674	1356	930	1050	682	682	682	682	81.0%	112.9%	100.0%	100.0%
	YORK HOSPITAL - RCB55	29	110 - TRAUMA & ORTHOPAEDICS		1488	936	744	504	682	561	341	341	62.9%	67.7%	82.3%	100.0%
	YORK HOSPITAL - RCB55	31	370 - MEDICAL ONCOLOGY		2092.5	1950	930	885	682	682	341	330	93.2%	95.2%	100.0%	96.8%
	YORK HOSPITAL - RCB55	32	320 - CARDIOLOGY		1518	1206	1116	1134	682	682	1023	1078	79.4%	101.6%	100.0%	105.4%
	YORK HOSPITAL - RCB55	33	301 - GASTROENTEROLOGY	361 - NEPHROLOGY	1488	1230	1116	1032	682	682	1023	1122	82.7%	92.5%	100.0%	109.7%
	YORK HOSPITAL - RCB55	34	340 - RESPIRATORY MEDICINE	301 - GASTROENTEROLOGY	1488	1320	1116	990	682	682	1023	1133	88.7%	88.7%	100.0%	110.8%
	YORK HOSPITAL - RCB55	35	430 - GERIATRIC MEDICINE		1302	1212	1116	1146	682	682	1023	1034	93.1%	102.7%	100.0%	101.1%
	YORK HOSPITAL - RCB55	37	430 - GERIATRIC MEDICINE		1116	1050	1302	1200	682	682	682	682	94.1%	92.2%	100.0%	100.0%
	YORK HOSPITAL - RCB55	39	430 - GERIATRIC MEDICINE		1488	1272	930	870	682	660	682	693	85.5%	93.5%	96.8%	101.6%
	YORK HOSPITAL - RCB55	36 - Acute Stroke Unit	430 - GERIATRIC MEDICINE		1860	1644	930	894	1364	1155	682	693	88.4%	96.1%	84.7%	101.6%
	YORK HOSPITAL - RCB55	Acute Medical Unit	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	4650	4095	3720	3352.5	2728	2409	2046	2354	88.1%	90.1%	88.3%	115.1%
	YORK HOSPITAL - RCB55	Coronary Care Unit	320 - CARDIOLOGY		1860	1507.5	345	300	1364	1122	0	11	81.0%	87.0%	82.3%	-
	YORK HOSPITAL - RCB55	Extended Stay Area	100 - GENERAL SURGERY	120 - ENT	1035	945	517.5	435	418	418	0	11	91.3%	84.1%	100.0%	-
	YORK HOSPITAL - RCB55	G1	502 - GYNAECOLOGY		1488	1284	744	660	682	616	682	561	86.3%	88.7%	90.3%	82.3%
	YORK HOSPITAL - RCB55	G2	501 - OBSTETRICS		1116	1056	558	390	682	638	341	616	94.6%	69.9%	93.5%	180.6%
	YORK HOSPITAL - RCB55	G3	501 - OBSTETRICS		744	714	372	228	682	671	0	0	96.0%	61.3%	98.4%	-
	YORK HOSPITAL - RCB55	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5580	4957.5	465	420	4092	3630	341	264	88.8%	90.3%	88.7%	77.4%
	WHITBY COMMUNITY HOSPITAL - RCBG1	Abbey	925 - COMMUNITY CARE SERVICES		697.5	697.5	1162.5	1162.5	341	341	341	550	100.0%	100.0%	100.0%	161.3%
	WHITBY COMMUNITY HOSPITAL - RCBG1	War Memorial	925 - COMMUNITY CARE SERVICES		930	720	1395	1027.5	341	330	682	374	77.4%	73.7%	96.8%	54.8%
	ARCHWAYS INTERMEDIATE CARE UNIT	Archways	925 - COMMUNITY CARE SERVICES		744	732	930	774	341	352	682	649	98.4%	83.2%	103.2%	95.2%
	MALTON COMMUNITY HOSPITAL - RCBL8	Fitzwilliam	925 - COMMUNITY CARE SERVICES		1162.5	982.5	1627.5	1782.5	682	693	682	671	84.5%	106.3%	101.6%	98.4%
	SELBY AND DISTRICT WAR MEMORIAL HOSPITAL - RCB07	Inpatient Unit	925 - COMMUNITY CARE SERVICES		1162.5	1080	1162.5	1147.5	682	407	341	616	92.9%	98.7%	59.7%	180.6%
	ST HELENS REHABILITATION HOSPITAL - RCBTV	St Helens	430 - GERIATRIC MEDICINE		930	885	1162.5	1005	682	605	341	341	95.2%	86.5%	88.7%	100.0%
	ST MONICAS HOSPITAL - RCB05	St Monicas	925 - COMMUNITY CARE SERVICES		637.5	607.5	810	742.5	341	341	341	341	95.3%	91.7%	100.0%	100.0%
	WHITE CROSS REHABILITATION HOSPITAL - RCBP9	Whitecross Court	430 - GERIATRIC MEDICINE		930	892.5	1162.5	1110	682	583	341	341	96.0%	95.5%	85.5%	100.0%

Blank page

D5

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Patient Experience Quarter 3 Report

Action requested/recommendation

The Board of Directors is requested to accept this report as assurance on the delivery of the Trust Patient Experience Strategy.

Summary

The Trust's Patient Experience Strategy was launched in September 2015. The strategy focuses on the five core principles of: listening; involving; reporting and responding; acting; and a culture of respect and responsibility.

A detailed implementation plan supports the strategy. This report gives an update on the Q3 Patient Experience activity and identifies priorities for the coming months.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Reference to CQC outcomes

There are no references to CQC outcomes although this report particularly relates to Outcome 1 (respecting and involving people who use services) and Outcome 17 (complaints).

Progress of report	This report is a summary of the more detailed reports which are received by

	Patient Experience Steering Group
Risk	No Trust-level risks highlighted. Risks identified through individual complaints and patient feedback are captured and escalated through directorate risk management.
Resource implications	Resources implication detailed in the report
Owner	Beverley Geary, Chief Nurse
Author	Hester Rowell, Lead for Patient Experience
Date of paper	January 2016
Version number	Version 1

Board of Directors – 27 January 2016

Patient Experience Quarter 3 Report

1. Introduction

The Trust's Patient Experience Strategy was launched in September 2015. The strategy focuses on the five core principles of: listening; involving; reporting and responding; acting; and a culture of respect and responsibility.

A detailed implementation plan supports the strategy. Five initial top priority actions from the implementation plan were identified.

This report provides a summary of the progress against the implementation along with updates on the Patient Experience Team's key functions:

- Complaints management
- Patient Advice and Liaison Service
- Friends and Family Test
- Volunteering Service.

2. Progress with Patient Experience Strategy Implementation Plan

The Implementation Plan identified five initial priorities. Significant progress has been made against these priorities, as evidenced below.

Agree and implement a migration plan for the Trust volunteering service from Human Resources to the Patient Experience Team	Complete	Staff and budgets now within the Patient Experience Team. All volunteers have received a letter from Bev Geary explaining the changes to the management of volunteering in the Trust. Six month plan for volunteer service in place.
Specify and procure a single contract for all (Friends and Family Test) FFT and national patient surveys - linking with HR to include staff FFT and the staff survey	Complete	Complete. New supplier, Patient Perspective, in place from 1 November 2015. First results from Patient Perspective received and cascaded to directorates.
Review the Trust complaints handling process against national best practice, identify gaps and implement improvements	In progress	National best practice toolkit for commissioners officially launched December 2015. A structure for assessing YTHFT complaints process has been developed based on this guidance. Guidance has been used to inform stage 1 changes to YTHFT complaints process. New guidance document has been produced for investigating officers. Individual and group training has been provided on the specific YTHFT complaints handling process

			as requested. This includes guidance on how to do an investigation, how to document the findings and how to write the response. Letter writing training took place for 30 staff who regularly act as investigating officers October 2015) New process in place supporting investigating officers to contact complainants (ideally by phone or face-to-face) at the start of the complaint investigation. New letter templates. New quality checking and sign-off procedure in place.
	Consult on, revise and obtain approval for a new Trust policy for handling enquiries, compliments, comments, concerns and complaints	In progress	Pre-work underway. New Datix Web system has been designed to handle patient feedback using these classifications. Links to PALS review (see below)
	Review the Trust Patient Advice and Liaison Service, agree and implement a service development plan to achieve greater visibility, accessibility and integration with the Patient Experience Team	In progress	Patient Experience Project Manager is coordinating this piece of work - started December 2015. Started with collating background information about the way PALS currently works. Membership of PALS review group has been agreed and first meeting invitations to be issued January 2016.

3. Complaints

New Complaints	July	August	September	October	November	December
York	20	15	25	24	22	13
Scarborough	19	20	30	13	15	13
Bridlington	1	1	2	1	1	2
Community*	1	1	1	4	0	0
TOTAL	**41**	**37**	**58**	**42**	**38**	**28**
Resolved outside procedure	4	5	No longer use this classification			

Dissatisfied	July	August	September	October	November	December
York	11	0	3	1	3	3
Scarborough	0	0	1	2	0	2
Bridlington	0	0	1	0	0	0
Community*	0	0	0	0	0	0
TOTAL	**11**	**0**	**5**	**3**	**3**	**5**

Community: including all community hospitals – Archways, Whitecross Court, Selby, Malton and Whitby

Top three complaint subjects for Q3

1. Communications/information to patients (written and oral)
2. All aspects of Clinical Treatment
3. Patient Care

Parliamentary and Health Service Ombudsman Cases: Outcomes Received in Q3

Complaints handling performance
The number of open complaint cases peaked at 124 in October. Since then team staffing levels have improved and the electronic Datix Web complaints management system has been implemented and embedded, which has significantly reduced the amount of administration required. At 12 January, current open cases = 73.

The number of cases where the response has taken >33 days peaked at 43, and has now reduced to 37. A focus on working with directorates to reduce this number is planned for February.

Developments to the complaints process
Following a successful pilot with the Emergency Department and Elderly Medicine, a new process has been adopted. This requires the investigating officer to contact the complainant directly at the start of the process to introduce themselves and talk through the issues raised. This conversation helps to clarify the key issues for the investigation, manage expectations and build trust.

A new style has been introduced for complaints responses. This asks investigating offers to use a letter style (rather than the old report style). This encourages a more personal tone and language. Some investigating officers have moved easily over to this style, but more support will be provided by the Patient Experience Team to increase the uptake over Q4.

Quality of responses
The complaint letter writing training in October was attended by 17 matrons and 13 deputy directorate managers. This resulted in excellent feedback from attendees and a tangible improvement in the draft letters received from this group of staff.

Guidance for all investigating officers has been developed and new templates, avoiding stock phrases and encouraging a personal style, have been rolled out as part of the Datix implementation.

Outcomes received this month	**Q3**
Referred back for further investigation	1
Not upheld	7
Partially upheld	3
Upheld	1
New Cases	3
Cases Currently Open	16

4. PALS

A review of the Patient Advice and Liaison Service has started from January 2016. A meeting including internal and patient/public stakeholders is planned for Q4 to confirm the scope of the review and outcomes required. Key issues are likely to include the visibility of PALS, logging of cases, the relationship with directorate colleagues to achieve swift resolution and types/format/frequency of reports.

The figures below show a reduction of PALS cases in November and December.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Theatres Anaesthetics and Critical Care	7	9	13	12	10	15	18	7	6
Applied Learning and Research	0	0	0	1	2	3	4	1	0
Chairman and CEO	0	4	1	6	1	4	9	6	7
Child Health	8	2	11	9	13	14	9	14	8
Allied Health Professionals	9	7	11	12	15	15	14	13	7
Community Services	8	7	12	21	16	13	16	8	7
Emergency Medicine	21	19	25	30	21	14	32	30	24
Estates and Facilities	19	23	25	32	22	47	55	29	16
Elderly Medicine	19	18	23	24	14	15	19	15	11
External to Trust	35	28	40	53	36	47	49	36	38
Finance and Performance	24	16	24	36	33	49	27	9	11
Head & Neck	11	17	24	21	13	25	25	13	8
Human Resources	8	1	2	14	14	27	20	16	21
Laboratory Medicine	0	0	1	0	2	2	2	1	4
Specialist Medicine	16	12	26	32	27	21	25	24	21
Medicine (General & Acute)	22	31	35	50	31	40	36	32	37
Nursing and Improvement	120	131	125	142	153	150	150	103	92
Obstetrics and Gynaecology	15	18	12	19	11	13	23	17	20
Ophthalmology	9	14	17	24	12	14	21	18	18
Operations	0	0	4	4	2	2	1	4	4
Orthopaedics & Trauma	26	13	25	25	20	22	23	23	18
Pharmacy	0	1	2	1	0	17	0	2	1
Radiology	10	13	10	21	17	38	15	9	14
Systems and Networks							31	23	21
General Surgery & Urology	43	31	30	48	42	12	54	51*	36
Sexual Health	0	1	0	6	3	1	4	2	0
Totals:	**430**	**416**	**498**	**643**	**530**	**631**	**682**	**506**	**450**

A depth review into the General Surgery and Urology cases for November was completed showing that key concerns being raised were about delays/cancellation of appointments and the communication around treatment plans/next steps in care.

5. Compliments

Compliments received by Chief Executive in Q3: **65**
This is in addition to those published in the media and received directly by ward staff.

Frequently occurring words:
Professional; Caring; Compassion; Efficiency; Grateful; Outstanding; Wonderful; Excellent; Appreciation; Gratitude; Reassuring; Teamwork

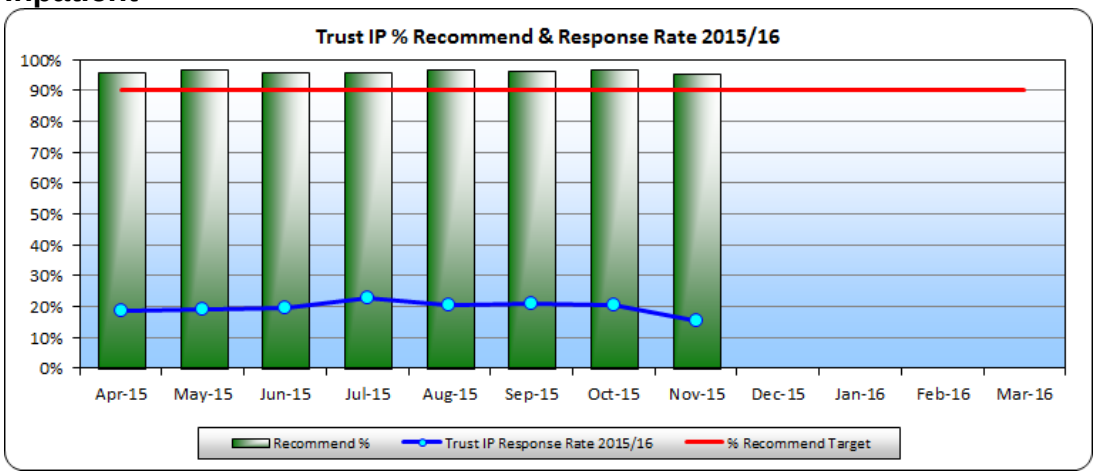
6. Friends and Family Test

The contract for Friends and Family test surveying and reporting was put out to tender in 2015. Patient Perspective were selected based on their focus on presenting data in ways that will be meaningful for staff and patients and their support for service-improvement.

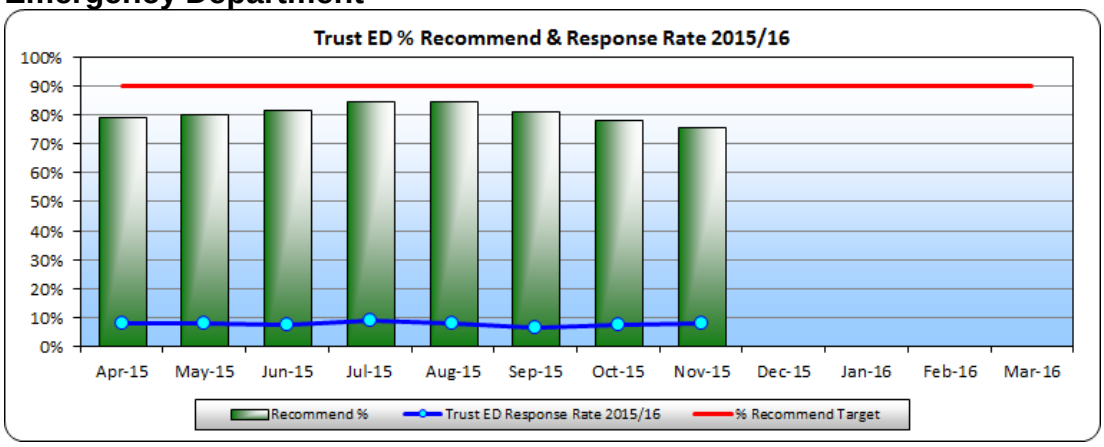
There was some disruption to FFT results throughout November in the handover between the two suppliers. Results for inpatient and ED are significant, but cards for maternity, community and outpatient areas were not provided until late in the month meaning that November results have been affected. We anticipate December results to return to normal.

The results for inpatients and ED are shown below:

Inpatient



Emergency Department



A new ward-level report format has been developed and has been very well received. The distribution lists for these reports have been updated to ensure all those who need them are getting the correct reports.

Recommendation rates – November 2015
Across all services:

90% were likely or extremely likely to recommend.
6% were unlikely or extremely unlikely to recommend.

% recommend	September	October	November	National
Inpatient	95%	97%	95%	95%
ED	81%	78%	76%	87%
Community	95%	96%	No responses	95%
Maternity	98%	96%	98%	95%

Actions for Q4

- Building relationships with matrons and directorate management to ensure FFT feedback is used effectively within local teams and action plans to address themes and/or response rates are in place where required.

- Look at how FFT reports are used to highlight and celebrate good practice and whether this could be developed further.

7. Volunteering

The volunteering service moved from HR to the Patient Experience Team in October 2015.

Currently the service is staffed by two 0.5WTE Band 3 administrators, one for Scarborough and one for York.

Volunteer numbers at January 2016 are:

	York	Scarborough	Bridlington	Malton
Number of volunteers	172	95	10	4
New applicants (to be interviewed)	9	12	6	0
Applicants in the process	16	39	4	1

A **six month plan** has been agreed which focuses on ensuring the basic building blocks are in place, from which the volunteering service can be grown and developed. This includes:

- Migrating the staff and budget from HR to Patient Experience
- Cleansing the databases of volunteer names, contact details, confirmation of governance checks/induction and roles to ensure they are complete and up to date
- Ensuring volunteer supervisors on wards clearly understand the role, are supported and maintain the necessary records
- Establish regular reports to Patient Experience Steering Group
- Catch up on the backlog of applications (from the four month period where the York administrator post was vacant)
- Ensure there are enough suitable placements for all applicants
- Develop a streamlined recruitment and induction process which is consistent across the whole Trust
- Review volunteer induction and mandatory training – looking for opportunities to provide access to e-learning
- Deliver thank you events for volunteers
- Develop an approach for recognising long service
- Develop an effective working relationship with Friends of York Hospital and the other voluntary services with whom the Trust works in partnership.

The new Volunteer Service Administrator for York started in post in November 2015.

In Q3 significant progress has been made in processing the backlog of applications and obtaining suitable placements. Significant time has been invested in re-establishing relationships with management, matrons and sisters to promote the opportunities from volunteering, build support and awareness of its potential, and develop new placements opportunities.

In Scarborough the Dining Companion role has been extended to Beech and Oak Wards and volunteers are in the recruitment process for these areas. Recruitment has started for volunteer visitors on Lilac Ward.

Records of York volunteers were not up to date. A full cleanse of the records has been completed, along with cross-checking central records against directorate records. All volunteers should now be registered on the central database, with confirmation that they have had the necessary pre-checks, have a confirmed supervisor and an agreed role description.

Governors have provided valuable support for volunteer interviews to enable applications to be processed in a timely manner.

A thank you event for Scarborough volunteers will take place on 15 January 2016. A similar event for York volunteers will be announced shortly. An event is planned for national volunteers' week: 1-7 June 2016.

8. Next Steps and Recommendations	
The next priorities, in Q4, to deliver the Patient Experience Strategy will focus on reporting and learning. This includes reviewing all directorate and Trust-level reporting to ensure that they are consistent, fit for purpose, and an effective basis for learning. The PALS review will be completed, making recommendations for any changes needed to meet patient and service needs and better support the staff within the team. The Board of Directors is asked to accept this report as assurance on effective delivery of the Patient Experience Strategy.	
Author	**Hester Rowell, Lead for Patient Experience**
Owner	**Beverley Geary, Chief Nurse**
Date	**January 2016**

Blank page

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 27 January 2016

Quarterly Infection Prevention and Control Report (Q3)

Action requested/recommendation

The Board of Directors is asked to receive the IP report for Q3 and acknowledge actions and interventions for reduction of HCAI.

Summary

In line with legislative and regulatory requirements, the Trust continues to acknowledge its responsibility to provide safe and effective infection prevention practice with the aim of reducing harm from avoidable infection that occurs either as a direct result of intervention or from contact with the healthcare setting.

This report summarises performance against these requirements for Q3 and aims to provide assurance of progress against interventions initiated to reduce the increased incidence of HCAI.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Reference to CQC

Regulation 12 of the Fundamental Standard – Safe care and treatment: (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Progress of report	Received by Quality and Safety Committee
Risk	Risk to patient safety from healthcare associated infection through variation in compliance with Infection Prevention practice and policy standards
Resource implications	Contractual fines when MRSA bacteraemia and *Clostridium difficile* incidence exceed trajectory and lapses in care identified.
Owner	Beverley Geary, Chief Nurse, Director of Infection Prevention and Control (DIPC)
Author	Vicki Parkin Deputy DIPC
Date of paper	January 2016
Version number	1

Board of Directors - 27 January 2016

Quarterly Infection Prevention and Control Report (Q3)

1. Introduction

Infection prevention interventions initiated in response to the period of increased incidence of Healthcare Associated Infection (HCAI) during Q1 and identified at Post Infection Review (PIR) continue to be delivered via formal and ward based practical training/education.

The impact of these interventions continues to demonstrate a downward trend in HCAI during Q3. Incidence per 100,000 occupied bed days is significantly less than in the same quarter for 2014/15 demonstrating improved compliance with and implementation of best practice, in particular invasive device management.

However *Clostridium difficile* infection (CDI) incidence during the quarter on York site has significantly increased; compared to that at Scarborough which has much improved. The Infection Prevention Team and the Antimicrobial Stewardship Team are working closely with Clinical and Governance leads to optimise medical management of cases following PIR outcomes. Principally this is through prompt and relevant sampling to inform appropriate antibiotic choice enabling de-escalation to a narrow spectrum drug or stopping its use. Clinicians are also being urged to discuss drug choice with the Microbiologist before prescribing to ensure clinical relevance.

A lack of isolation capacity and decant space to enable high level disinfection following clusters and annual deep clean continue to create a risk to CDI reduction; 2/8 cases in November were subject to bed moves and 4/8 environment audits were not completed. These risks have been reported via DATIX and discussed with relevant Operational Leads/ Matrons and included in the IP message of the month to facilitate dissemination and learning.

MRSA emergency screening shows some improvement in Q3 following targeted education and support to staff in acute admission areas and MRSA policy revision following national guidance. IP will continue to work with acute admission area staff to sustain improvement.

2. Update: Incidence and Performance

Information below describes HCAI incidence in Q3 and gives comparisons with the previous 2 quarters:

MRSA Bacteraemia: total cases – 6
Q1 – 6 cases. Q2 – 0 cases. Q3 – 0 cases. National Trajectory – zero tolerance, fines incurred for each case.

MSSA Bacteraemia: total cases – 30
Q1 – 11 cases. Q2 – 9 cases. Q3 – 10 cases predominantly in medical and elderly directorates**.** Local trajectory – less than 30 cases, no financial penalty.

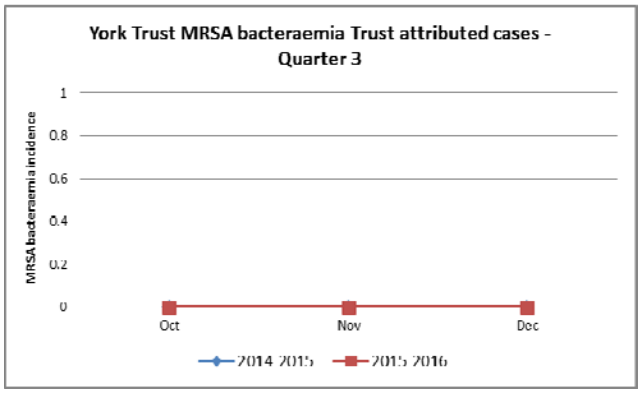
***Clostridium difficile* infection (CDI):** Total cases – 50 currently against a trajectory of 48.

Number of lapses in care – 9.
Number pending decision – 1.
Number awaiting PIR – 12

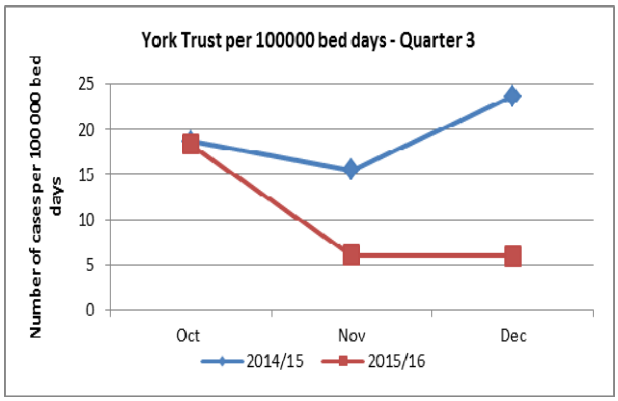
Q1 – 21 cases. Q2 – 14 cases. Q3 – 15 cases predominantly on the York site where action plans are agreed at PIR with clinical and nurse leads. Fines incurred if lapses in care are identified and trajectory is exceeded.

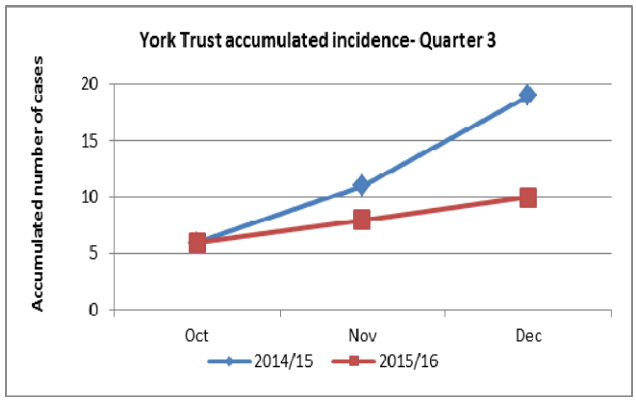
Comparative incidence data below describes 2014/15 and 2015/16 incidence by site for the same time period:

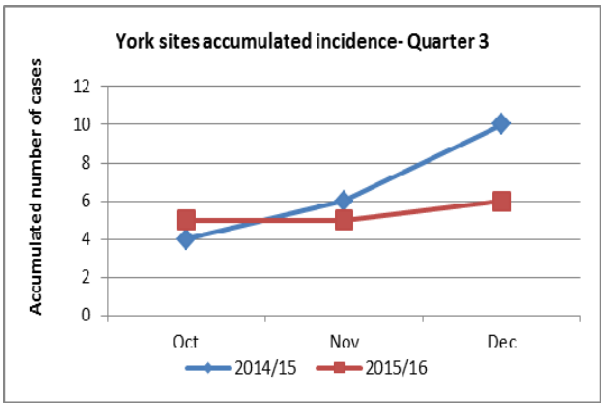
MRSA bacteraemia Trust attributed cases

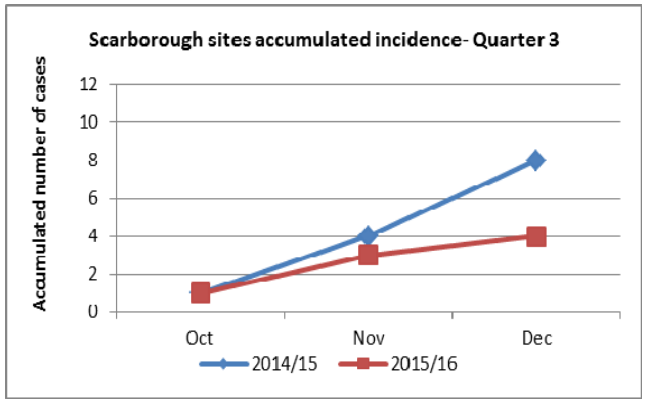


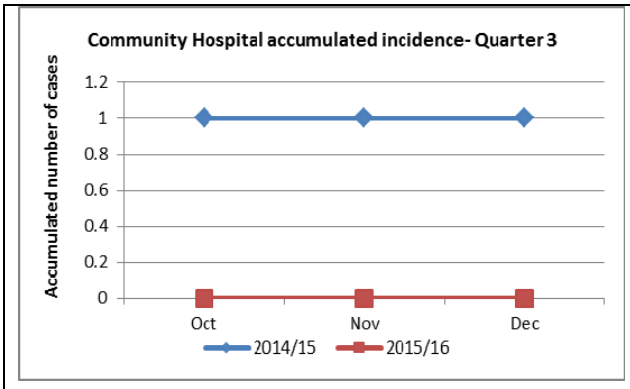
MSSA bacteraemia Trust attributed cases



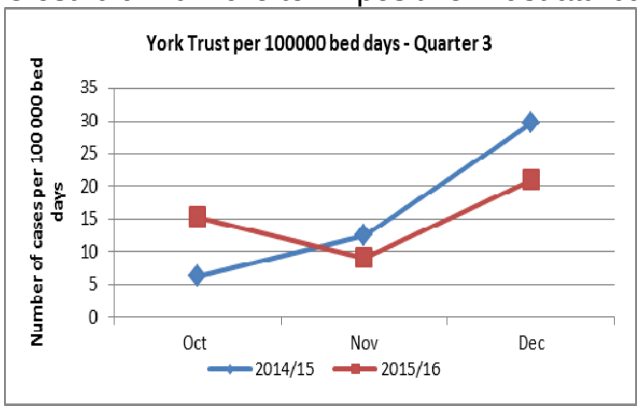


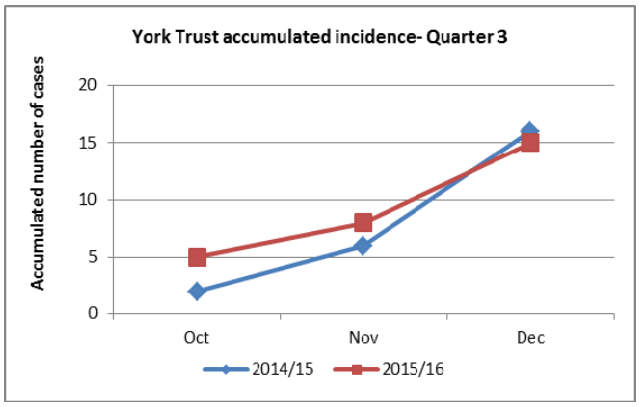


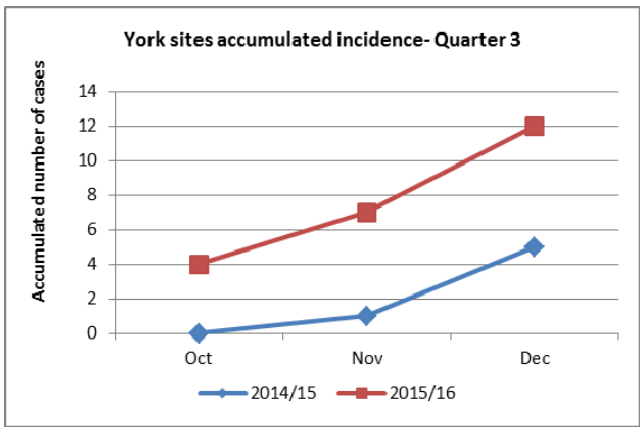


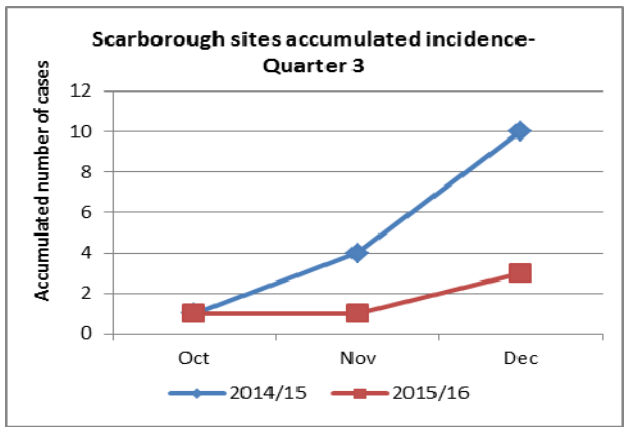


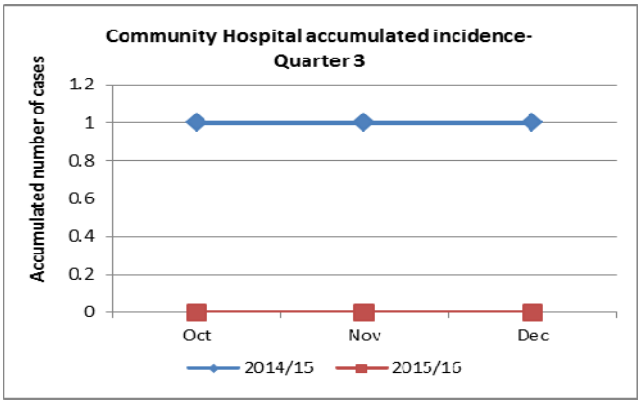
Clostridium difficile toxin positive Trust attributed cases











Ward based training and education sessions are delivered to staff in high inidence areas to address and raise awareness of PIR outcome and best practice in line with Trust IP polices/guidelines with subsequent dissemination at PNLF, Senior Nurse meetings and Medical staff training. IP message of the month disseminates learning from PIR outcomes throughout the organisation

Post Infection Review:
Work continues to refine this process to ensure effective review, optimise care and learning opportunities. We have attempted to make attendance at PIR meetings as accessible as possible by varying times and locations therefore meeting the requirements of attendees. Whilst engagement from clinical and nursing leads has improved in some areas it remains a challenge however there has been some improvement which has enabled significant catch up of outstanding cases requiring PIR to be reviewed.

Working closely with our Commissioners reviewing PIR for CDI, agreement has been reached with 9 cases that no `lapses in care` occurred thereby preventing financial penalty for cases that occur above trajectory. A further two cases are being considered for Q3. Where `lapses` are thought to have occurred in line with local and national standards, these are documented in an action plan at PIR for Matrons and Ward managers to deliver supported by IP with the aim of preventing recurrence by improving and sustaining best practice.

Norovirus:
Thirteen wards were either closed or partially closed due to Norovirus during Q3 – 10 wards were closed in York Hospital however the duration of closure was not prolonged due to the vigilance and effective management by ward staff**.** The IP Team are developing a multifaceted approach to raising awareness of the management of winter vomiting virus across the Organisation. This includes ward based support visits focussing on isolation practice using a recently developed toolkit, IP briefings at Senior Nurse and PNLF meetings, communication through staff room/staff brief and IP message of the month.

Antimicrobial Stewardship:
Monthly antimicrobial audits throughout the Trust continue to show improvement in adherence to the prescribing standards which are as follows:

- All antimicrobial prescriptions shall have an indication recorded on the prescription
- All antimicrobial prescriptions shall have a duration or review date recorded on the prescription

Areas which perform poorly in these audits continue to have extra input from the antimicrobial pharmacy team to help improve the quality of their prescribing.

Audit data below shows our compliance with these prescribing standards and demonstrates improvement during Q3:

Green = >95%, Amber = 90%-95%, Red = <90%

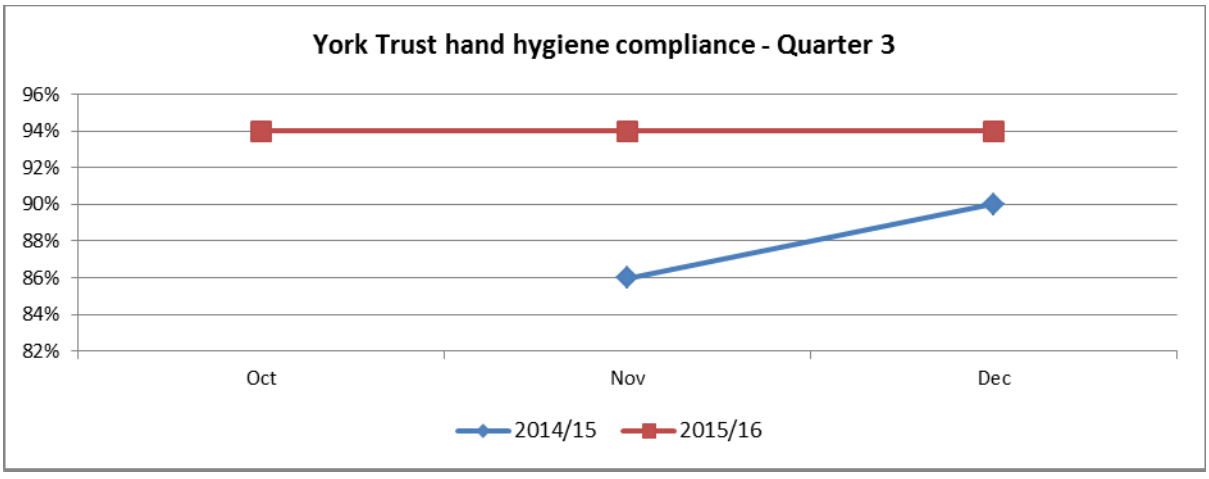
Parameter		Q3 2014/15	Oct	Nov	Dec	Q3 2015/16
Antimicrobial pathway compliance with indication (information from Antimicrobial Stewardship Team)	Elderly	88%	90%	93%	95%	93%
	Head + Neck	77%	x	60%	100%	80%
	Medicine	92%	88%	84%	93%	88%
	Obstetrics + Gynaecology	with surgery	67%	33%	100%	67%
	Specialist Medicine	with medicine	89%	80%	100%	90%
	Surgery + Urology	85%	88%	88%	87%	88%
	Trauma + Orthopaedics	87%	73%	95%	89%	86%
	Trust	86%	88%	86%	92%	89%

Antimicrobial pathway compliance with duration or review date (information from Antimicrobial Stewardship Team)	Elderly	87%	88%	88%	92%	89%
	Head + Neck	78%	x	80%	33%	57%
	Medicine	88%	80%	82%	88%	83%
	Obstetrics + Gynaecology	with surgery	67%	67%	71%	68%
	Specialist Medicine	with medicine	78%	60%	100%	79%
	Surgery + Urology	87%	93%	78%	84%	85%
	Trauma + Orthopaedics	85%	67%	62%	79%	69%
	Trust	85%	83%	81%	87%	84%

The use of broad spectrum antibiotics is being closely scrutinised by the Antimicrobial Stewardship Team. The launch of the 'pip-taz hotline' in Q3 encourages nursing colleagues to escalate piperacillin-tazobactam prescriptions to the pharmacy team for urgent follow-up.

Weekly antimicrobial stewardship ward rounds are undertaken on both acute sites. These include members of the pharmacy antimicrobial team together with microbiology consultants/registrars, and proved successful in reviewing inpatient antibiotic prescriptions. These rounds have a particular focus on broad spectrum antibiotics such as piperacillin-tazobactam.

Hand Hygiene:
A Trust wide improvement plan implemented late last year following external audit that demonstrated 32% - 60% compliance has led to greater understanding of the World Health Organisation 5 moments for hand hygiene amongst clinical staff. The hand hygiene observation audits have shown consistently improved compliance and less variation in practice across all sites identified through external review



3. Review of Governance

Recommendations from the external governance review are being developed by the IPT for implementation early 2016

Terms of reference have been developed and a new governance structure agreed.

4. Conclusion

Collective and multidisciplinary responsibility for IP is essential to maintaining a downward trend, enhancing patient safety and reducing costs.

Interventions to reduce HCAI incidence continue to impact on a downward trend improving patient safety and outcome however more work and compliance with sampling to optimise treatment and management of CDI is required to improve patient safety and incidence rates.

IP continue to work with IT, Nurse and Medical leads to identify initiatives and actions for improvement.

5. Recommendation

The Board of Directors is asked to receive the IP report for Q3 and acknowledge actions and interventions for reduction of HCAI.

6. Reference and further Reading

Relevant Legislation and Guidance:

- The Health and Social Care Act 2008:Code of Practice on the prevention and control of infections and related guidance, updated July 2015
- NICE Infection and Prevention Quality Standard 61 April 2014
- Epic 3: National Evidence-Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England 2014

Author	**Vicki Parkin Deputy Director of Infection Prevention and Control**
Owner	**Beverley Geary, Director of Infection Prevention and Control**
Date	**January 2016**

Finance and Performance Committee –19 January – Boardroom, York Hospital

Attendance: Mike Keaney, Chairman, Michael Sweet, Andrew Bertram, Juliet Walters, Anna Pridmore, Gordon Cooney, Sue Rushbrook

Apologies: Graham Lamb

Observing: Zoe Nicholl, Organisational Development & Improvement Learning Facilitator
Alison Hornsby, Corporate Improvement Team Programme Manager

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
1.	**Last Meeting Notes 15 December 2016**	The agenda covered the following AFW and CRR items AFW EF1 DoF1,2, 4,7 CRR CE1	MK welcomed ZN and AH to the meeting. The Committee requested an amendment to the minutes on the Emergency Department discussion. The minutes state that '*SR reminded the Committee that Monitor have a number of quality standards that the Trust is required to comply with, including, the length of time to see a doctor. There has been a reduction in the length of time it takes to see a doctor recently. A second standard is the reduction of the number of patients leaving the department, again there has been a reduction in the number seen.'* The Committee asked for the minute to be amended to say there had been a reduction in the number of patients leaving the department without being seen and treated. LT asked for an amendment to be made to the		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
		DoF 1-3	paragraph acknowledging that the performance for November was very poor. She requested that the paragraph acknowledged that performance against the Emergency Care Standards for November was very poor. The Committee agreed with the amendment. There were some typographical errors noted by the Committee, it was agreed those would be corrected. The remainder of the minutes were approved as a true record of the meeting.		
2.	**Matters arising**		GC commented on a recent meeting held with Monitor. He reported that his discussions had confirmed that if the Trust was in formal turnaround the performance would relate back to the fines. AB added that a lot of new information was now available about the current penalty regime and access to the sustainability funds. He explained that the new contract currently being discussed includes a reduced penalty regime, but if the Trust does not deliver on key aspects of service, it will then have difficulty accessing the sustainability funds. He did not expect all penalties to disappear, he thought there would be penalties relating to mixed sex accommodation and 52 week breaches would remain.		
3	**Risk Register**		JW reported that there were some amendments that needed to be made to her risk register and that would be picked up with Ms Jamieson outside the	The Committee found the inclusion of the risk register	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			meeting. AB drew the Committee's attention to a new risk included on his risk register around the use of the strategic capital.	helpful.	
4	**CQC report**		The Committee considered the report and noted the progress against the actions. The Committee agreed that the actions allocated to the F&P Committee were already included in the agenda and discussed as part of Committee business. The Committee requested that two items relating to the clinical strategy be moved to the Executive Board. The Committee understood that the Board would receive a quarterly report on progress against completing the actions. The next report was planned for the March Board meeting.	The Committee were assured that the actions included in the CQC action plan were items already included in the Committee's agenda.	
4.	**Overview of TAP**		GC presented his monthly status report. He highlighted the briefing circulated by AB to all staff reiterating the seriousness of the declining financial position. GC reported that he had met with JNCC and staff side to discuss the Turnaround Avoidance Programme (TAP) and gain views on what else could be included in the programme. GC explained that some of the information being provided to wards includes details of the cost of fines and what that cost would buy in the organisation, (e.g. X fines = running a ward for a day). **Fines eradication** - GC noted there had been an increase for the third consecutive month in the fines against ED 4 hour target and Ambulance Turnaround times.	The Committee were generally assured by some of the progress that has been made. But the Committee continues to be concerned about what they see as a lack of measurable targets.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			Ambulance Turnaround – It has been noted that the level of fines are calculated on YAS data. The Trust has now compared this data to the information included in CPD and identified significant discrepancies. The Trust has written to the CCGs highlighting the differences and is currently in discussions with the CCG around the findings. **ED observational analysis –** GC explained that the observational analysis of Scarborough ED was an example of some of the extra work currently being undertaken. He described the work and the four key points that had been identified. JW welcomed the work and added that the Corporate Improvement Team (CIT) had completed an excellent piece of work. The Committee asked what would follow the observations. GC explained that the work would help towards improving the achievement of the ED target. He added that every piece of work that is undertaken is referred back to the TAP action plan. The Committee asked if the initiatives that had been introduced had had any impact. GC confirmed the actions taken had had a positive impact on performance. JW added that it is important that the Trust focuses on the right things to continue to achieve the Emergency Care Standards that includes reviewing staffing models and investing in staff groups such as AHPs. JW outlined the work that is being undertaken to address all four of the		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			points identified by the observational analysis. She confirmed that this work associated with everything else the Trust is involved with will, she believes, result in the Trust achieving the required 90% of Emergency Care standards. **Investment and timescales –** GC referred the Committee to the extract from the business case register. GC explained that TAP has been designed to encompass everything the Trust does. Some of the corporate changes that have been made include changing the PMM approach and reviewing the approach to business cases. The Committee discussed the extent of the programme and heard that Monitor at their recent visit had been of the view that the Trust should be tougher and re-consider how much is actually included in the programme. AB explained that the visit had been from a member of Monitor staff who usually would visit a Trust as the Trust enters formal intervention. AB advised that a report will be presented to Monitor on Wednesday summarising the findings from the visit. He added that the comment had been made that the level of engagement from clinicians and other staff was impressive and not something she had seen very often. It was further suggested by Monitor that the Trust should be more proactive on reducing non-recurrent CIP delivery. AB explained that he would take on the suggestions, but would also create a safety net system.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			The Committee discussed the impact of not continuing to follow pieces of work. It was recognised by the Committee that the complexity of the organisation and the impact of stopping specific actions/projects could be extensive across the organisation. **Staff Shortages –** GC advised the centralised recruitment team had now been put in place and work was underway to design a role for bands 1-4 ward support workers. The Committee discussed the reduction in costs. MS suggested that the Trust has to be able to demonstrate to Monitor that it is making the right changes. JW added that in her view, Monitor needed to have the confidence in the Executive Team to deliver the requirements and for the NEDs to continue to challenge and push for further improvements. AB added that at some stage he believes intervention from Monitor will occur, but he is not sure what their intervention will do.		
5.	**Work Stream 1: Operational Reports**		LT presented the performance report. **ED –** She reported there had been an improvement in performance in December. The marginal gains are as a result of a lot of work being undertaken and demonstration of good leadership and engagement from staff. She acknowledged that	The Committee remained concerned about the dip in performance during the first two weeks in January, but was assured by the work that had been undertaken and continues to be in place.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			performance had deteriorated in the first two weeks in January, but that should be taken in the context of there being no intermediate care beds available in York along with an increased number of patients being admitted through ED, the flood seen in York at the end of December and the number of staff on leave. She added the measures put in place in December continue to be in place. SR added that it should be noted that during the end of December and the beginning of January there are a number of organisations that close down, including GP practices. JW added that the level of complexities in the ED department needs to be recognised. The middle grade doctors provide the senior out of hour's decision making, at present there are only 2 middle grade doctors in place. When the Trust is at full complement there would be 8. JW gave examples of some of the complexities being dealt with including the DVT pathway which was initially intended to be provided through community services. This has been changed and the Trust is now providing this pathway. It has recently been transferred to the York Ambulatory Care Unit. In Scarborough there are no intermediate care beds available. LT added that when the Trust compares the first two weeks in January 2016 with January 2015, it can be seen that the Trust is in a better position. In January 2015 there was a MAJAX and the Trust was cancelling elective procedures. Neither has occurred this January.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			The Committee asked where it could be seen that sustained improvements had been made. JW commented that recently there had been more non-admitted patients than admitted. When the triage system used in the ED was changed in December 2015, this position changed as a result the department is more effective at moving patients to the Ambulatory Care Unit and out of the Emergency Department. SR provided examples of other changes that have been tested and introduced and have demonstrated improvements and given a boost to the Emergency Department. The Committee discussed the attendance at Scarborough Emergency Department over the Christmas and New Year period and noticed it was phenomenally high. The Committee asked about the progress of discussions around Yorkshire Doctors. JW advised that Yorkshire Doctors are experiencing the same problems as the Trust in recruiting doctors. In York the Trust is continuing to push for a 7 day out of hour's service and is working with the CCG to establish how the current position can be managed. In Scarborough discussions are continuing with the CCG on the transfer of minor injuries to Yorkshire Doctors. The Trust is currently seeking clarification of a start date for the service. **18-weeks –** The Trust achieved the incomplete pathway for Q3, although two specialities did fail the target. Anaesthetics (Pain) improved their	The Committee was pleased to see the Trust had achieved the 18 week target for quarter 3.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			compliance during December but the Trust will incur some fines as a result. Discussions are continuing with the CCG regarding the commissioned pathways and this service. General Surgery was the other specialty that failed the incomplete target. Performance was 91.51% and the Trust will incur some fines. In November General Surgery achieved this target. LT reminded the Committee that the fines for breach of the 18-week target are doubled and at present the level of fines incurred for the year for this target are less than they were last year. The backlog has increased during the month. Factors affecting the increase include theatre staffing shortages, a shortage of beds and planned reduced activity as part of the Winter Plan. To address these issues, ward 29 has been reopened and patients are being offered the opportunity to be treated in Bridlington. A specific theatre nurse staffing advert is currently live and it is hoped this will attract suitable candidates and reduce vacancies. Working list initiatives are being run at the weekend voluntarily by the Directorates without any additional costs. LT added that further working list initiatives will be developed and the position is being reviewed on a week by week basis. **Cancer –** the Trust achieved all targets for quarter 3 with the exception of 62 day first treatment. In November, the Trust did not pass the 14 symptomatic breast, 31 day subsequent surgery, 62 day first treatment.	The Committee was assured by the improved performance in Cancer Services.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			LT described the current discussions being held with Hull around lung surgery patients. There are a number of patients waiting for treatment following a change to the administration system used in Hull. **Diagnostics -** The Trust achieved the target for the fourth month running.		
7.	**Work Stream 3: Finance Report**		AB presented the financial position as at December 2015. He explained there had been a further deterioration in the financial position with an underlying deficit growing from £8.3m to £9.6m. The adverse variance from plan has increased from £6.2m to £8.8m (including restructuring costs). The actual income and expenditure deficit is £14.7m, but that includes the full (technical, non-cash) charge of £4.6m associated with the loss of Whitby Hospital asset transferring ownership to NHS Property Services and £500k related to MARS payment. Monitor will exclude both charges from any assessment of our underlying position. **Expenditure** - AB referred the Committee to the pay costs chart and explained that the trend line of pay against budgets was now at significant variance from plan. This related mainly to continued locum and agency pressure. Total gross agency spend in December was £2.2m. AB added that there is a shortage of middle grade doctors and the position with junior doctors is also precarious. The Trust is looking at the development of other roles such as ACPs, but in the short term the pressure will continue.	The Committee was concerned about the deteriorating financial position. The Committee was assured by the comments made by the Finance Director, but recognised the genuine possibility that Monitor will decide to take formal interventional action.	

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			The Committee asked if the cap recently introduced applied equally to locum and nursing staff. AB confirmed it did. At present there were still issues about the price being paid for locums as it can on occasion be above the capped level, but he was expecting that to change. He added that part of the requirement for accessing the sustainability funding is that the Trust stays within the capped levels. AB referred to the drug costs chart and noted that the expenditure is above budget, but this is not adversely impacting on the Trust as the costs primarily relate to high cost drugs which are excluded from tariff, for which commissioner income is matched. Clinical supplies and services spend in December exceeded budget as directorates were increasing stock levels to cover the Christmas and New Year periods. Other cost provides an analysis of other expenditure. In December there was a significant variance from plan which relates to the high volume of subcontracted work to maintain 18-weeks RTT performance and numerous miscellaneous expenditure items. **Income –** AB referred to the charts. He explained that elective income was disappointing in December and follows a low month in November. Income from Day Case has also been low in December as has income from outpatients. Non-elective income		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			increased in December reaching its highest level for the current financial year. **Forecast outturn position –** AB reported a further deterioration in the forecast outturn position for 2015/16. The revised forecast suggests the deficit position of £16.4m at the end of the financial year. It should be noted that this figure includes Whitby Hospital asset of £4.6m and total restructuring costs of £0.6m. The underlying deficit is £11.2m. AB explained the background to the revised forecast and highlighted the risk with the forecast position for the quarterly Board declaration. AB explained that other discussions were being held with the Executive Board around how the Trust should address the further deterioration. He added that the recent briefing sent to staff made it clear that there was a toughening of approach and the position was serious. For the final 10 weeks of the financial year the Trust will only accept essential expenditure and further briefings will be sent out to reinforce this message. The Committee asked if there were any concerns about the ability of the CCGs to pay their liabilities. AB explained that discussions are being held with the CCG and at this stage there is some confidence that some elements of their outstanding liabilities will be paid such as penalties, other aspects such as work undertaken by the Trust above plan are subject to further discussions.		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
8	**Service Line Reporting**		SK presented the report outlining that the reference costs had moved from 97 to 100. This puts the Trust at the national average. SK advised that an external reference cost audit including coding had been undertaken, at present the Trust had not received the draft audit report, but once it was received it will be presented to the F&P Committee. SR noted the benefits that were being seen from her team and SK's team working together.	The Committee were assured by the comments and the report.	
8.	**Work Stream 3: Efficiency Report**		SK highlighted the significant pressure being placed on finance managers at present as a result of around the tighter timeline for the production of the first draft of the Annual Plan. The Committee asked if it is expected the Trust will achieve the CIP target. SK confirmed he did expect the Trust to achieve the CIP target. The Committee discussed the CIP target for 2016/17 and understood that at present it could be higher than the current year. That does not however take into account some of the work that will be undertaken in the last quarter to convert non-recurrent savings into recurrent savings.	The Committee were assured by the comments and the report.	
11.	**Any other business**		The Committee discussed the overall assurance that could be gained from the progress in relation to finance and performance issues. MK and MS were both of the view that they remained concerned about the continuing organisational difficulties. They proffered the view that 80% of the problems being		

	Agenda Item	AFW/ CRR	Comments	Assurance	Attention to Board
			experienced in the Trust could be resolved by having the right people in the right place. They did recognise that the staffing issues are significantly affected by the national shortage of available candidates to take up the roles.		
12.	**Next Meeting**		The next meeting is arranged for 16 February 2016.		

F1

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Finance Report

Action requested/recommendation

The Board is asked to note the contents of this report.

Summary

This report details the financial position for York Teaching Hospital NHS Foundation Trust for the period ended 31 December 2015.

At the end of November the Trust is reporting an Income and Expenditure (I&E) deficit of £14.7m against a planned deficit of £5.9m for the period. The Income & Expenditure position places the Trust behind its Operational plan.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☒

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Andrew Bertram, Finance Director
Author	Graham Lamb, Deputy Finance Director
Date of paper	January 2016
Version number	Version 1

Briefing Note for the Finance & Performance Committee Meeting 19 January 2016
Briefing Note for the Board of Directors Meeting 27 January 2016

Subject: December 2015 (Month 9, Quarter 3) Financial Position

From: Andrew Bertram, Finance Director

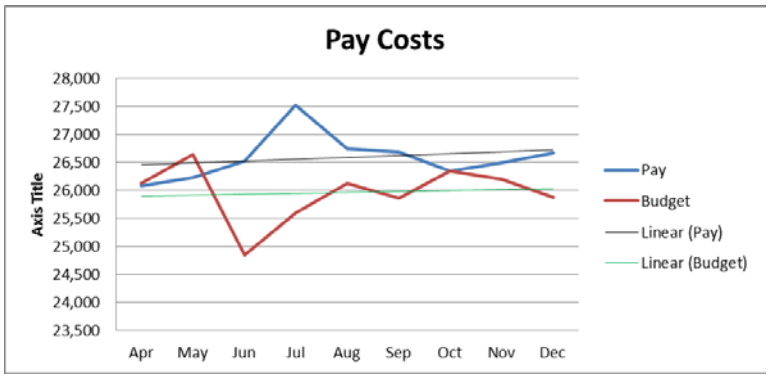
Summary Reported Position for the Period to December 2015

The month of December has seen a continued deterioration in our financial position, with the underlying deficit growing from £8.3m to £9.6m. The adverse variance from plan has increased from £6.2m to £8.8m (including restructuring costs).

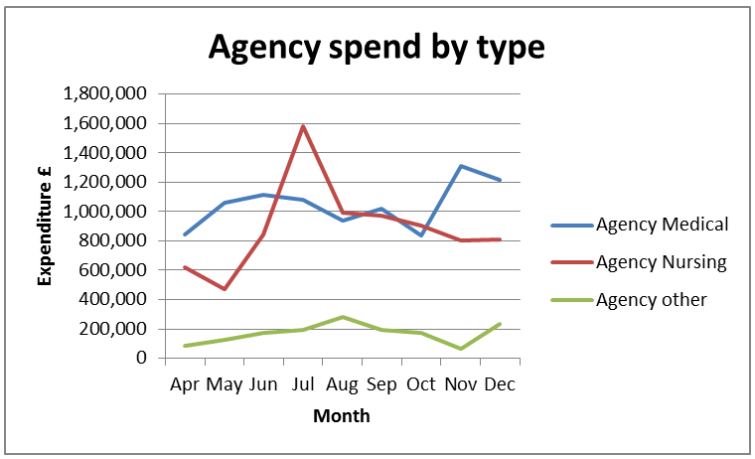
The report shows an actual income and expenditure deficit of £14.7m but the Board are reminded that this includes the full (technical, non-cash) charge of £4.6m associated with the loss of the Whitby Hospital asset transferring ownership to NHS Property Services. Also included in this position are the Board approved MARS payments, totalling £0.5m and made in December as part of the exit from the organisation of a number of individuals. These charges are considered restructuring costs. Both the asset transfer and restructuring costs are excluded in any Monitor assessment of our underlying position.

Expenditure Analysis

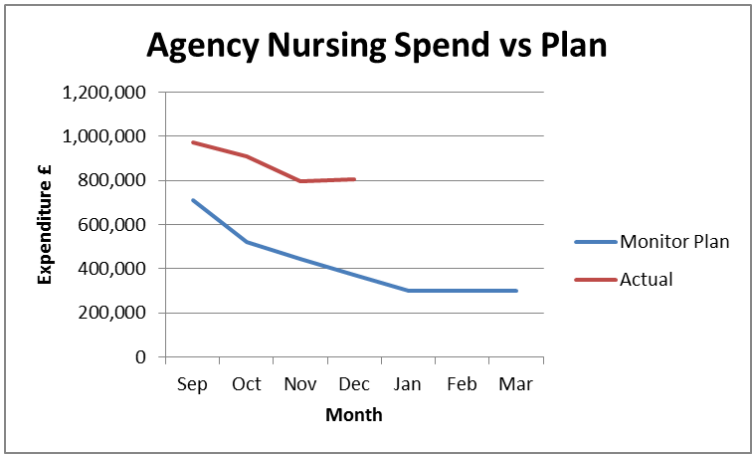
Overall in the month of December expenditure has been higher than recent months at £39.9m. In November expenditure totalled £38.4m. Of note is that the MARS payments of £0.5m are included in December's expenditure, so underlying expenditure was £0.9m higher in December than November. Essentially this related to pay costs £0.2m higher, drug costs (matched by income above plan) of £0.3m, clinical supplies & services £0.6m higher and other costs £0.2m lower than November.



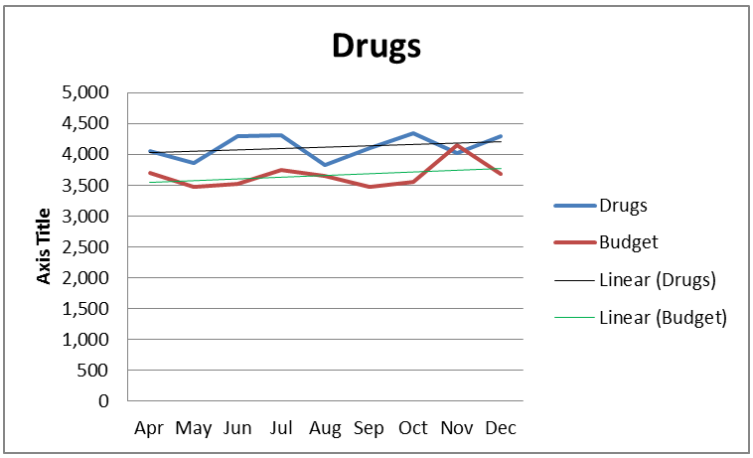
The chart shows pay costs against budget, including trend lines. Clear from the chart is a significant variance from plan (£0.8m) in December, relating in the main to continued locum and agency pressure. Total gross agency spend in December was £2.2m. Continued attention is required to reduce agency reliance.



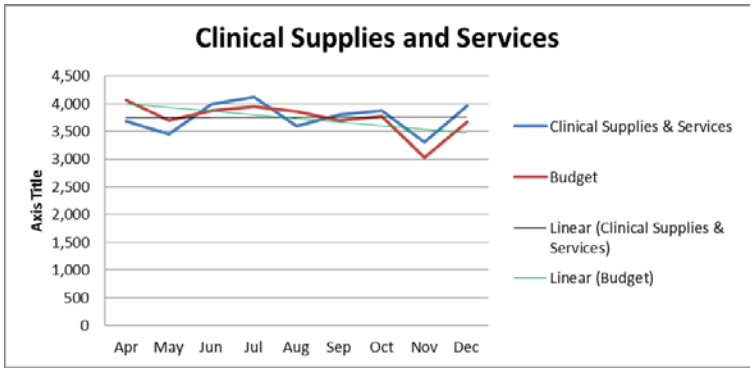
This chart analyses agency spend, looking specifically at staff group. The chart shows a continued (slow) reduction in nurse agency costs as recruitment improves, controls are enhanced and rates are negotiated downwards. Worrying is the increase in medical agency costs in November that have continued into December. This relates to increasing pressure from filling consultant, middle grade and junior rota vacancies.



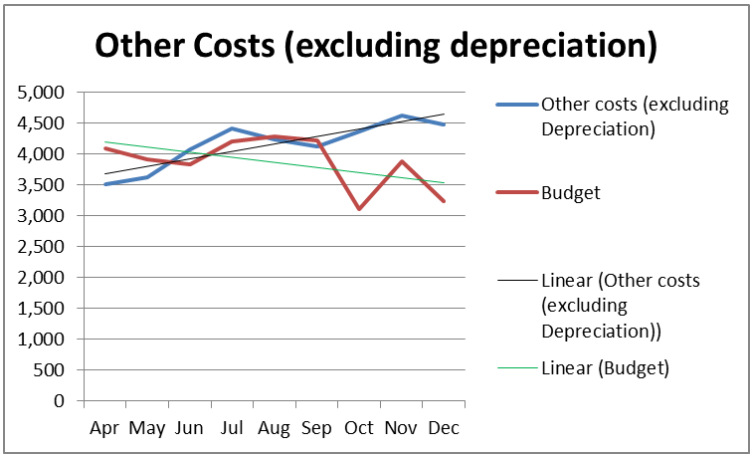
This chart looks at agency nursing spend against the Monitor improvement trajectory taking the Trust to the mandated 4% agency spend rate by March 2016. Whilst in recent months we have been tracking the improvement gradient the spend levels are markedly above target. Notably December has stalled. The Board are aware of recruitment difficulties and the control measures requiring Chief Nurse Office sign off.



This chart analyses drug expenditure. Of note is expenditure of £0.6m more than budget in month. However, this is not adversely impacting on the Trust's bottom line due to this primarily relating to high cost drugs excluded from tariff, for which commissioner income is matched.



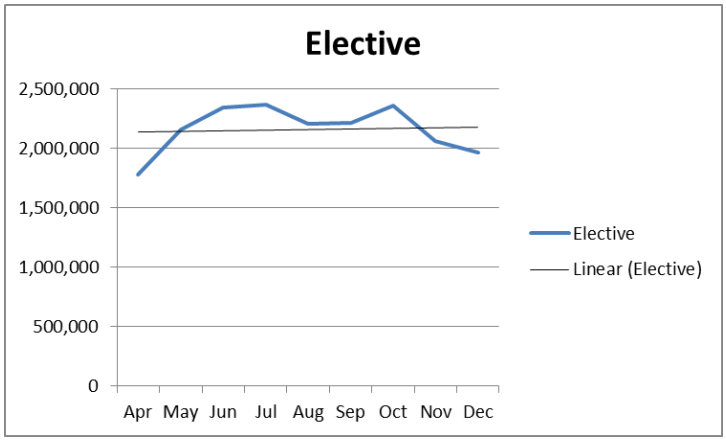
The same analysis is provided for clinical supplies & services. In this regard spend has closely matched budget throughout the year, with a downward overall trend. However, in December spend exceeded budget by £0.3m. This position has been adjusted for stocking up in preparation for the Christmas and New Year period.



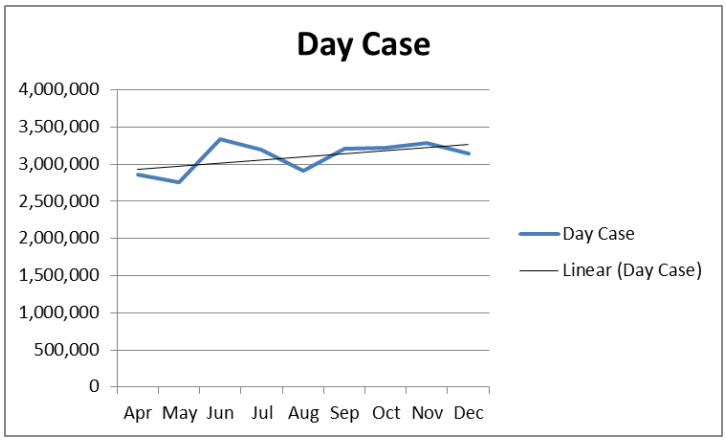
The final chart shows the same analysis for other expenditure. Of note is a significant adverse variance to plan (£1.2m) for December. This relates to high volumes of subcontracted work to maintain 18-week RTT performance and numerous miscellaneous expenditure items including £0.1m profiling bed maintenance charges, a £0.1m utility pressure and £0.1m personal injury pension benefit payments.

Income Analysis

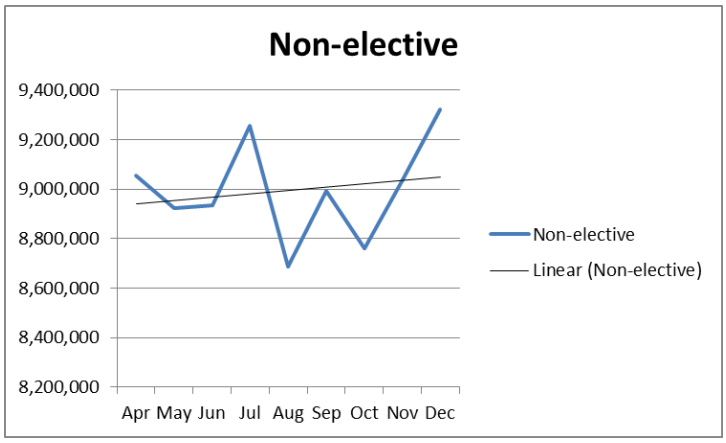
An analysis of income shows a disappointing month in December, as predicted given the impact of Christmas and New Year on elective and outpatient work particularly.



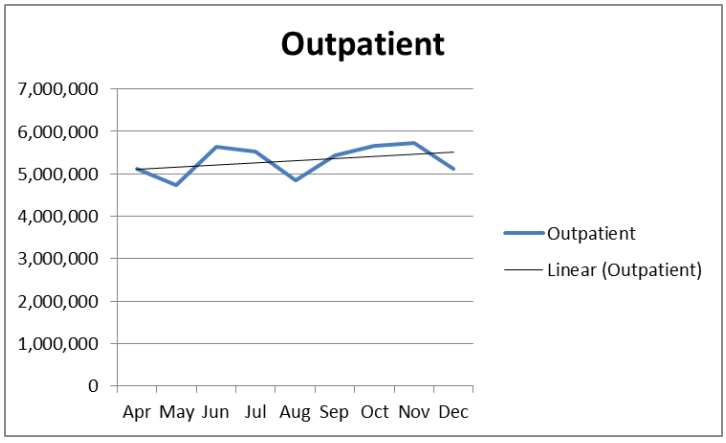
The chart shows monthly elective income (elective in-patients). This is based on freeze data where this is available, otherwise flex data or estimates are included. We know from past analysis that, despite October looking high, we cancelled significant levels in month due to bed difficulties and theatre staffing shortages. November income was lower still and December has been extremely disappointing.



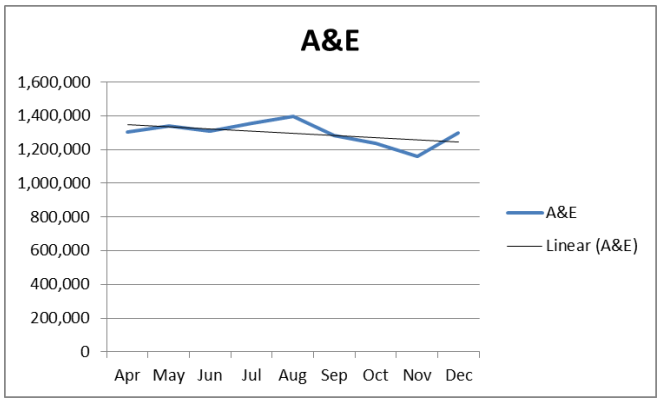
The same analysis is provided for day case income. Although fairly consistent throughout the year, December has been low.

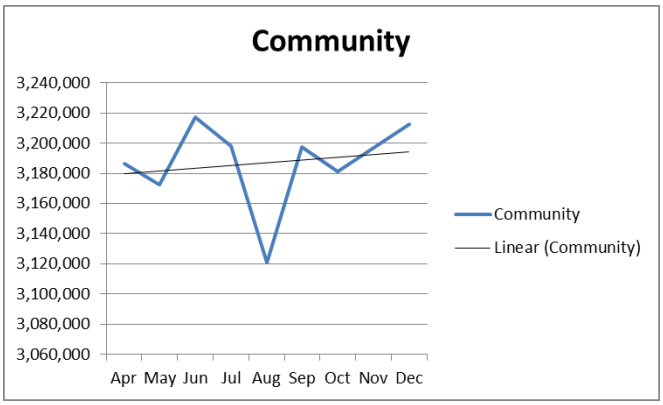


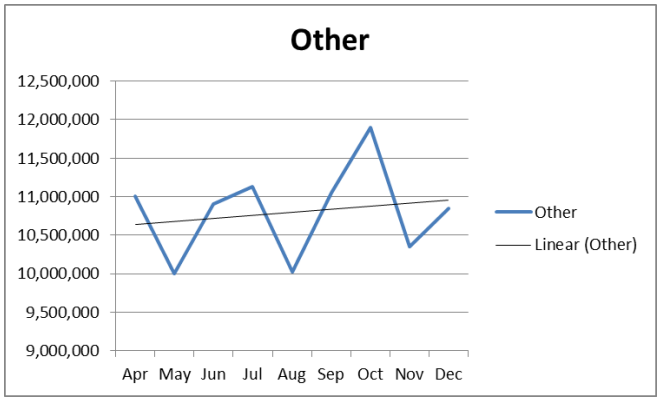
Non-elective income was up in December, reaching its highest value for the current financial year. Of note are the upward trend line and the fact that upper and lower control limits are relatively tight to the trend line, noting the scale of this particular chart.



Outpatient income was particularly disappointing in December, some £0.7m below recent monthly levels. This income stream is clearly impacted by the extended bank holiday period.







In relation to A&E, Community and Other clinical income streams there are no significant issues I would wish to bring to the Board's attention.

Forecast Outturn Position

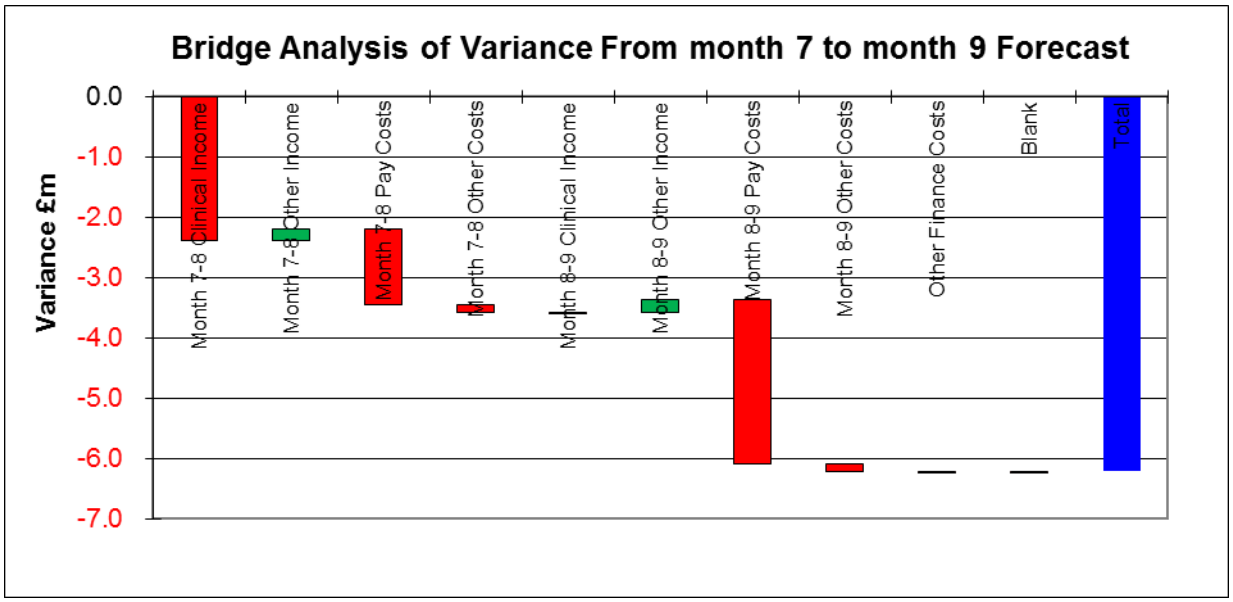
As usual the detailed finance report provides the latest estimate of the Trust's financial outturn.

I would wish to bring to the Board's attention a further deterioration in our forecast outturn. The latest forecast, revised for the adverse impact of December, suggests a deficit outturn position of £16.4m. Of note this includes the transfer of the Whitby Hospital asset at £4.6m and total restructuring costs of £0.6m. The underlying deficit is therefore £11.2m.

The table below summarises the movements in our most recent reported forecasts.

	Annual plan 2015/16	Q2	M7	M8	Movement M7 - 8	M9	Movement M8 - 9
	£m	£m	£m	£m	£m	£m	£m
Clinical income	404.80	417.00	417.78	415.38	-2.40	415.38	0.00
Other income	48.10	52.60	52.88	53.07	0.19	53.29	0.22
Total income	**452.91**	**469.60**	**470.65**	**468.44**	**-2.21**	**468.66**	**0.22**
Total expenditure	-437.85	-456.53	-457.81	-459.18	-1.37	-462.04	-2.86
EBITDA	15.05	13.06	12.84	9.26	-3.58	6.62	-2.64
Other operational and non operational I&E	-22.46	-22.72	-22.72	-23.00	-0.28	-23.00	0.00
Deficit	-7.41	-9.66	-9.88	-13.74	-3.86	-16.38	-2.64
FSRR	3.00	3.00	3.00	2.00		2.00	

This movement is further analysed in the bridge analysis detailed below.



At the close of Q2, we reported an expected deficit of £9.7m against a planned position of £7.4m. This remained broadly similar at month 7 although income improvements and equal and opposite expenditure pressures were adjusted for. Both the Q2 and month 7 forecast positions indicated a FSRR of 3.

At month 8 (November) lost elective work, related to on day cancellations and theatre staffing issues, had continued for the second month in a row. There was little prospect of recovery in December and concerns over non-elective activity levels in Q4 presented concerns over elective recovery during this period too. Additionally the Board were briefed at the time on an emerging readmissions issue affecting the early months of the financial year. Detailed data reconciliations showed considerably higher than estimated readmission reductions to income. Thirdly, and more marginally, the Trust was requested to continue the MSK service following the cessation of the CCG procurement exercise. Given the reported staffing level reduction a reassessment of likely reduced income levels was made. As a result of these issues the forecast outturn clinical income level was reduced by £2.4m with a small compensating gain adjustment of £0.2m relating to other income improvements.

The income position has been reassessed at month 9 and no further material revision has been made. In effect, the forecast activity/income level for Q4 is now assumed at average Q3 levels. The forecast assumes the CCGs honour payments in relation to non-elective work, where this is presently being queried on the basis of both volume increase and the legitimacy of charges for the Scarborough Surgical Admissions Unit and the Ambulatory Care Unit.

In terms of expenditure; at month 8 (November) a decision was taken to revise the expenditure forecast based on two key issues. Firstly, whilst nurse recruitment had recently been at a good level and agency spend had been maintained at levels lower than the peaks in the early part of the year, staffing levels remained a source of concern, agency usage continued and the Trust has had difficulty in safely meeting the obligations of the agency target reductions. Through nurse agency controls, through agency rate negotiation and through the development and promotion of the Trust's internal nurse bank (introduction of weekly pay, enhanced rates, preferential access to additional hours, etc) we have seen an improving nurse agency position but this has not been at the targeted improvement rate. In relation to medical agency staff; despite the deployment of the HCL system for managing medical locum spend, despite increased controls and despite the introduction of national agency rate caps and greater rate negotiation, expenditure in November increased quite markedly. These issues caused a revision to the expenditure forecast at that time.

In addition, in maintaining 18-week RTT performance increased levels of subcontracting of elective work has been necessary. The need for subcontracting had been exacerbated by the month 7 and 8 elective cancellations. Clearly this activity increases spend directly and offers no opportunity for the Trust to earn a margin from this work.

As a result of these issues the month 8 forecast expenditure level was increased by £1.4m.

The position has been reassessed at month 9 and a further deterioration in the forecast outturn expenditure has been predicted. This totals £2.9m and relates in the main to an expectation of continued difficulties in reducing agency and locum expenditure to targeted levels. Of note is the continued, and previously untypical, medical agency costs and a stalling in the continued reduction of nurse agency costs. Also included in this deterioration is a worsening of non-pay of £0.1m based on the poor December position.

The Board should be aware of the risks with this forecast position. Based on recent trends this is a challenging forecast outturn and is conditional on no reductions in current income

levels (from both changes in activity or commissioner challenge). The forecast is also conditional on the recently deployed expenditure control measures making an impact in Q4. To hit the target it is the case that non-essential expenditure must be deferred to the new financial year. Specific action has been taken in this regard, including enhanced controls, greater scrutiny, widespread written briefings and specific face-to-face Directorate briefings from the Corporate Team.

The Board will be kept up to date with regards to pressures impacting our forecast throughout the Q4 reporting period.

Also of note, is that the revised forecast (at both month 8 and month 9) moves the Trust's FSRR to 2. This has implications for the Board in terms of its Monitor governance declarations as a rating at this level indicates increased stress on the organisation's finances. In previous reporting quarters the Board has been able to indicate a reasonable expectation of delivering a FSRR of at least 3. For Q4 this is no longer the case.

The Board will receive a first draft financial income and expenditure plan at the January meeting. At the time of writing this report the plan is under development as the Trust has only just received the final expected planning guidance and details of the nationally provided sustainability funding. What is clear is that the business rules and funding arrangements for 2016/17 will have a positive impact on the Trust's finances. The Board will need to consider the 2016/17 FSRR (which is likely to score a rating of 3), as well as the Q4 FSRR (scoring 2), in making its Q4 governance declaration. Advice will be sought from Monitor as to the governance declaration expectation as it is most likely the Trust will have a short term one quarter impact of a FSRR of 2, moving quickly to a FSRR of 3.

Finance Performance Report

January 2016

Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Summary Income and Expenditure Position
Month 9 - The Period 1st April 2015 to 31st December 2015

York Teaching Hospital NHS
NHS Foundation Trust

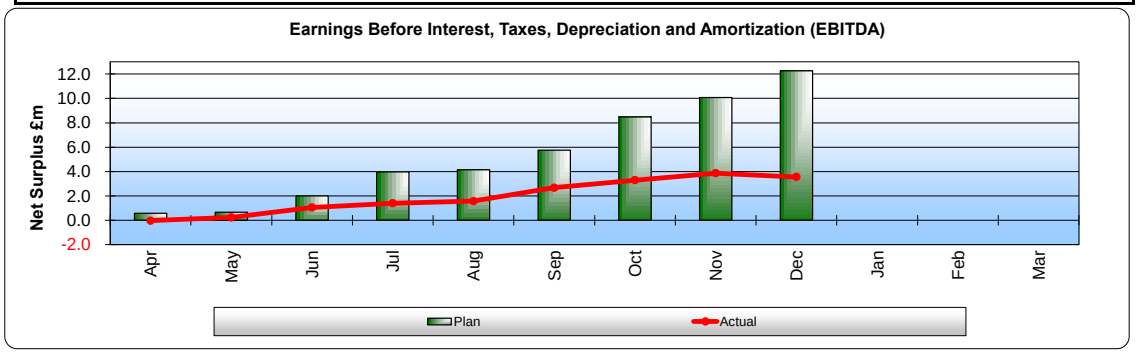
Summary Position:

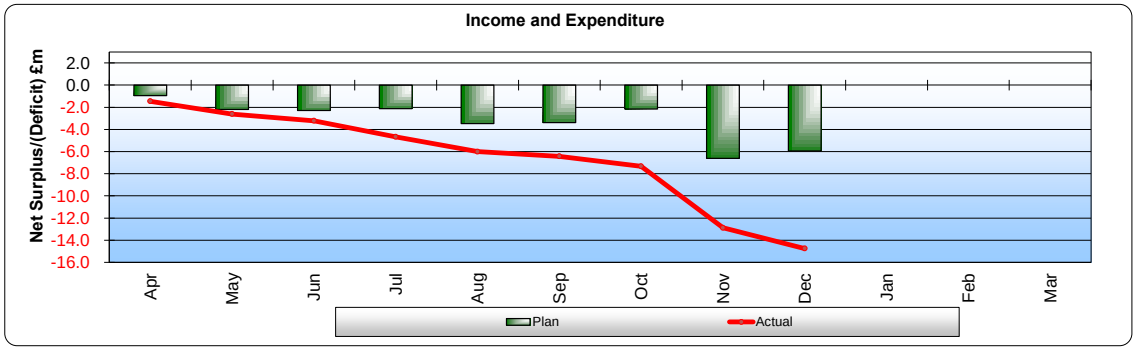
* The Trust is reporting an I&E deficit of £14.75m, placing it £8.8m behind the operational plan.

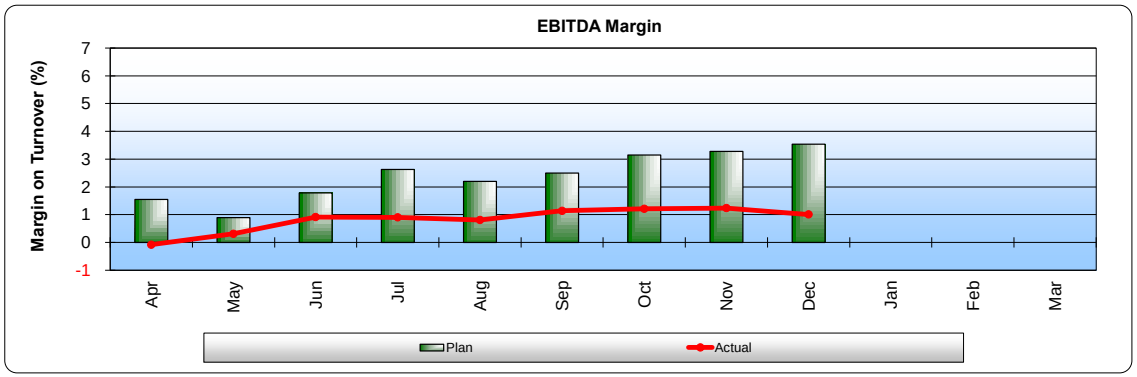
* Income is £5.9m ahead of plan, with clinical income being £3.2m ahead of plan and non-clinical income being £2.7m ahead of plan.

* Operational expenditure is ahead of plan by £14.6m, with further explanation given on the 'Expenditure' sheet.

* The Trust's 'Earnings before Interest, Depreciation and Amortisation' (EBITDA) is £3.5m (1.01%) compared to plan of £12.3m (3.54%), and is reflective of the reported net I&E performance.







	Annual Plan	Plan for Year to Date	Actual for Year to Date	Variance for Year to Date	Forecast Outturn	Annual Plan Variance
	£000	£000	£000	£000	£000	£000
NHS Clinical Income						
Elective Income	25,509	19,250	18,982	-268	24,525	-984
Planned same day (Day cases)	33,871	25,406	27,252	1,846	36,310	2,439
Non-Elective Income	104,287	78,358	78,986	628	107,311	3,024
Outpatients	66,517	49,761	46,706	-3,055	67,689	1,172
A&E	14,883	11,105	11,394	289	16,039	1,156
Community	33,199	25,382	28,036	2,654	35,571	2,372
Other	131,929	98,684	99,756	1,072	127,932	-3,997
	410,195	**307,946**	**311,112**	**3,166**	**415,377**	**5,182**
Non-NHS Clinical Income						
Private Patient Income	1,036	777	730	-47	973	-63
Other Non-protected Clinical Income	1,890	1,417	1,386	-32	1,848	-42
	2,926	**2,195**	**2,116**	**-79**	**2,821**	**-105**
Other Income						
Education & Training	14,333	10,750	11,498	748	15,420	1,086
Research & Development	4,156	3,117	3,580	463	4,573	417
Donations & Grants received (Assets)	0	0	0	0	0	0
Donations & Grants received (cash to buy Assets)	600	450	554	104	739	139
Other Income	17,628	13,303	14,755	1,452	19,567	1,939
Transition support	10,907	8,180	8,179	-1	10,906	-1
	47,624	**35,800**	**38,566**	**2,766**	**51,205**	**3,581**
Total Income	**460,746**	**345,941**	**351,794**	**5,853**	**469,403**	**8,658**
Expenditure						
Pay costs	-313,628	-233,656	-239,307	-5,651	-318,551	-4,923
Drug costs	-44,101	-32,997	-37,161	-4,164	-49,186	-5,085
Clinical Supplies & Services	-45,009	-33,589	-33,750	-161	-44,862	147
Other costs (excluding Depreciation)	-47,065	-34,795	-37,441	-2,646	-49,442	-2,377
Restructuring Costs	0	0	-577	-577	-578	-578
CIP	4,734	1,357	0	-1,357	0	-4,734
Total Expenditure	**-445,069**	**-333,680**	**-348,236**	**-14,556**	**-462,618**	**-17,549**
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)	**15,677**	**12,261**	**3,558**	**-8,703**	**6,785**	**-8,891**
Profit/ Loss on Asset Disposals	-4,500	-4,500	-4,586	-86	-4,583	-83
Fixed Asset Impairments	-300	0	0	0	-300	0
Depreciation	-11,000	-8,250	-8,250	0	-11,000	0
Interest Receivable/ Payable	100	75	107	32	143	43
Interest Expense on Overdrafts and WCF	0	0	0	0	0	0
Interest Expense on Bridging loans	0	0	0	0	0	0
Interest Expense on Non-commercial borrowings	0	0	0	0	0	0
Interest Expense on Commercial borrowings	-335	-251	-276	-25	-367	-32
Interest Expense on Finance leases (non-PFI)	0	0	0	0	0	0
Other Finance costs	0	0	-19	-19	-19	-19
PDC Dividend	-7,040	-5,280	-5,280	0	-7,040	1
Taxation Payable	0	0	0	0	0	0
NET SURPLUS/ DEFICIT	**-7,398**	**-5,945**	**-14,746**	**-8,801**	**-16,380**	**-8,982**

Contract Performance

Month 9 - The Period 1st April 2015 to 31st December 2015

York Teaching Hospital NHS
NHS Foundation Trust

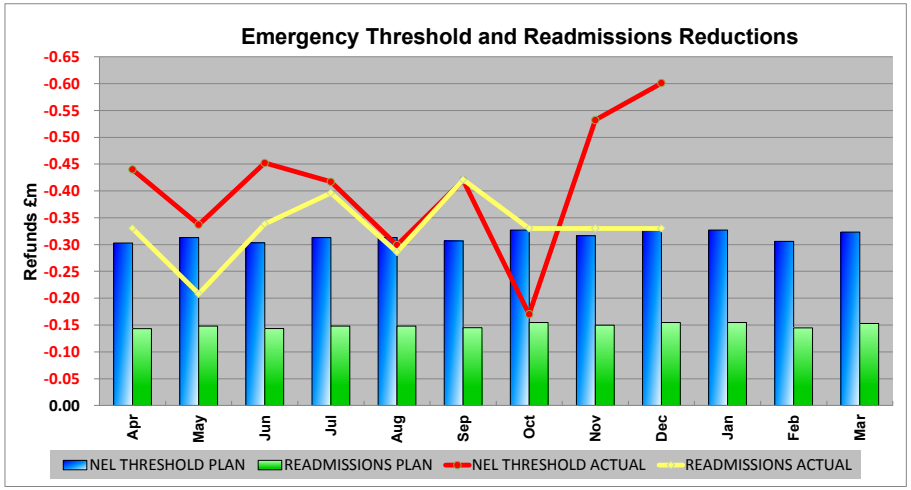
Contract	Annual Contract Value	Contract Year to Date	Actual Year to Date	Variance
	£000	£000	£000	£000
Vale of York CCG	194,547	145,169	152,523	7,354
Scarborough & Ryedale CCG	74,959	55,626	59,411	3,785
East Riding CCG	37,600	27,768	30,512	2,744
Other Contracted CCGs	23,762	17,657	17,484	-173
NHSE - Specialised Commissioning	35,241	26,502	26,330	-172
NHSE - Public Health	14,466	11,112	11,093	-19
Local Authorities	7,001	4,888	4,673	-215
Total NHS Contract Clinical Income	**387,576**	**288,722**	**302,026**	**13,304**

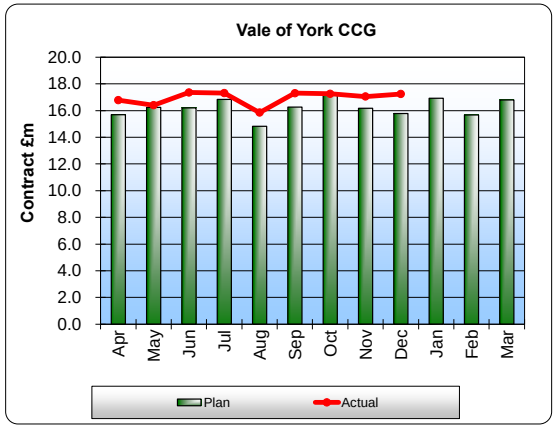
Plan	Annual Plan	Plan Year to Date	Actual Year to Date	Variance Year to Date
	£000	£000	£000	£000
Non-Contract Activity	9,896	7,439	9,221	1,782
Risk Income	12,723	11,785	0	-11,785
Total Other NHS Clinical Income	**22,619**	**19,224**	**9,221**	**-10,003**

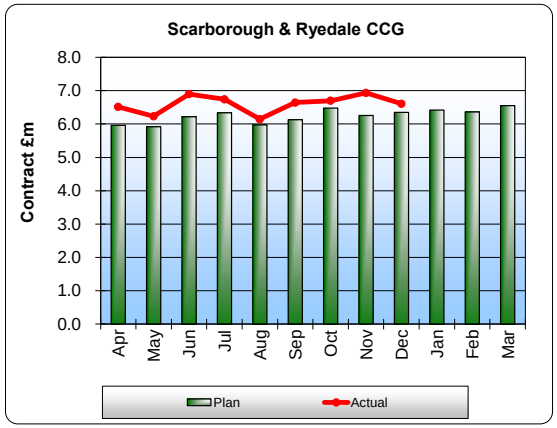
Specialist registrar income moved to other income non clinical	-1041
Winter resilience monies in addition to contract	906

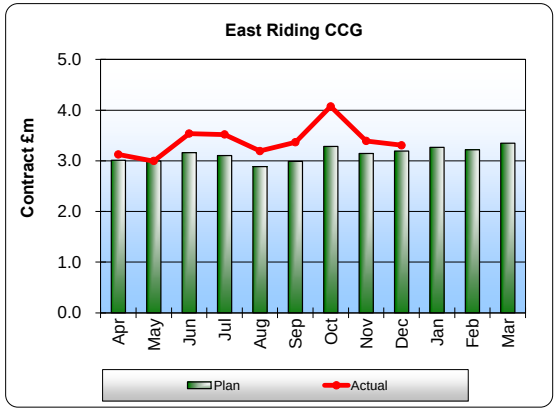
Total NHS Clinical Income	**410,195**	**307,946**	**311,112**	**3,166**

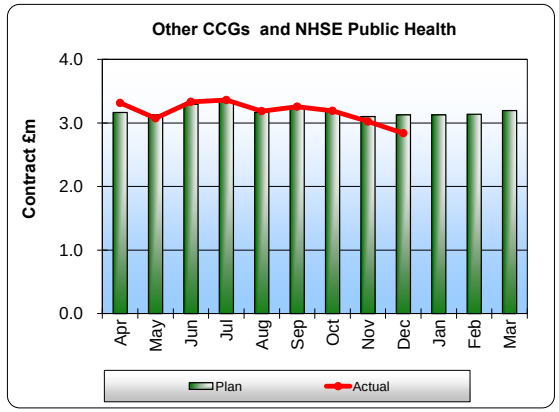
Activity data for the most recent month is partially coded; the month prior to this has over 90% coded, and earlier months are fully coded. There is therefore some element of income estimate involved for the uncoded portion of activity.

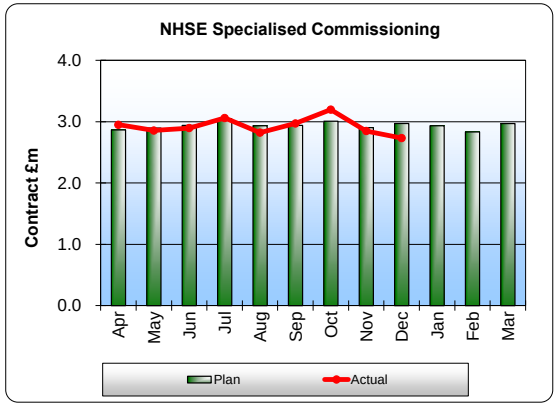


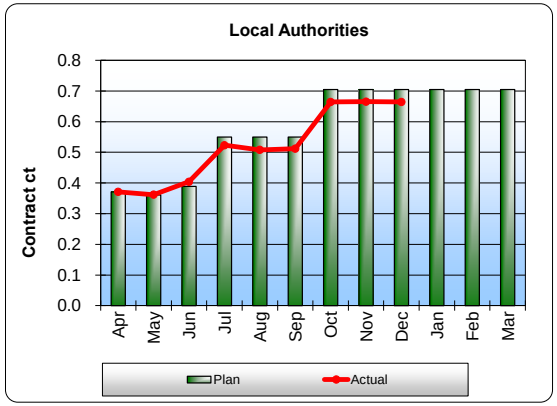












Expenditure Analysis
Month 9 - The Period 1st April 2015 to 31st December 2015

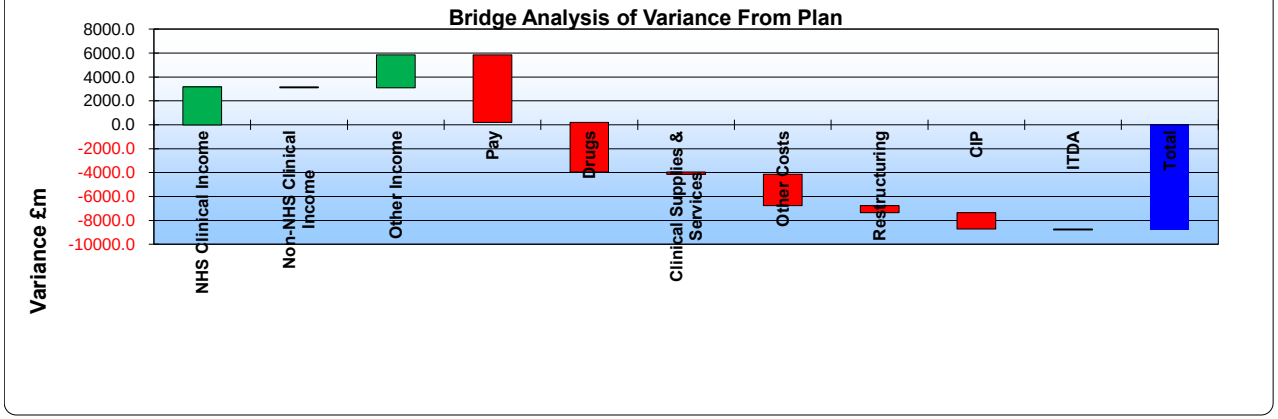
York Teaching Hospital NHS
NHS Foundation Trust

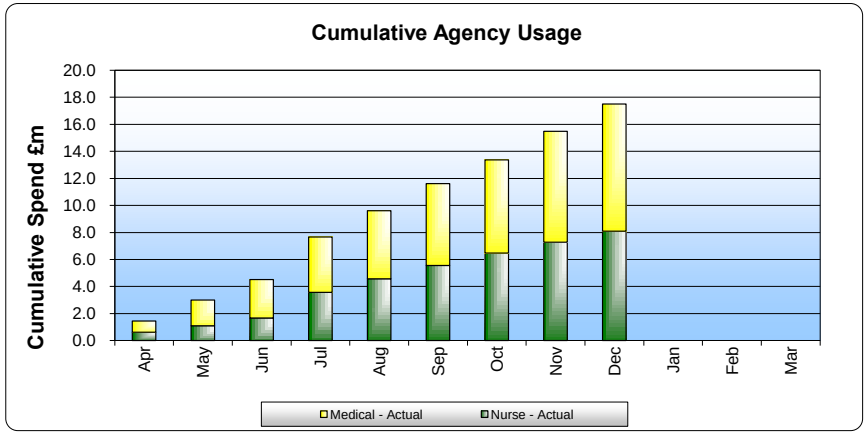
Key Messages:

There is an adverse expenditure variance of £14.6m at the end of December 2015. This comprises:

* Pay budgets are £5.7m adverse, linked to continued high locum and agency costs.
* Drugs budgets are £4.2m adverse, mainly due to pass through costs for drugs excluded from tariff.
* CIP achievement is £1.4m behind plan.
* Other budgets are £3.3m adverse.

Staff Group	Annual	Year to Date								Previous	Comments
	Plan	Plan	Contract	Overtime	WLI	Bank	Agency	Total	Variance	Variance	
Consultants	54,414	40,753	35,883	0	1,333	0	4,400	41,616	-862	-660	
Medical & Dental	29,365	21,927	19,447	0	151	0	5,010	24,608	-2,681	-2,375	
Nursing, Midwifery & Health Visting	94,351	70,538	60,628	394	268	2,465	8,090	71,846	-1,307	-1,276	
Professional & Technical	9,643	7,242	5,928	92	129	0	410	6,558	684	644	
Scientific & Professional	17,241	12,861	11,580	67	24	0	261	11,933	928	798	
P.A.M.s	22,212	16,710	14,773	38	208	0	282	15,303	1,407	1,287	
Healthcare Assistants & Other Support Staff	43,816	32,846	31,815	517	103	25	163	32,623	224	193	
Chairman and Non-Executives	161	120	121	0	0	0	0	121	-1	-1	
Executive Board and Senior Managers	14,682	10,967	10,051	5	0	0	46	10,102	865	721	
Administrative & Clerical	34,083	25,484	24,047	153	126	0	272	24,598	886	778	
Agency Premium Provision	3,717	2,788	0	0	0	0	0	0	2,788	2,667	
Vacancy Factor	-10,057	-8,582	0	0	0	0	0	0	-8,582	-7,640	
TOTAL	**313,628**	**233,656**	**214,273**	**1,267**	**2,343**	**2,490**	**18,934**	**239,307**	**-5,651**	**-4,863**	



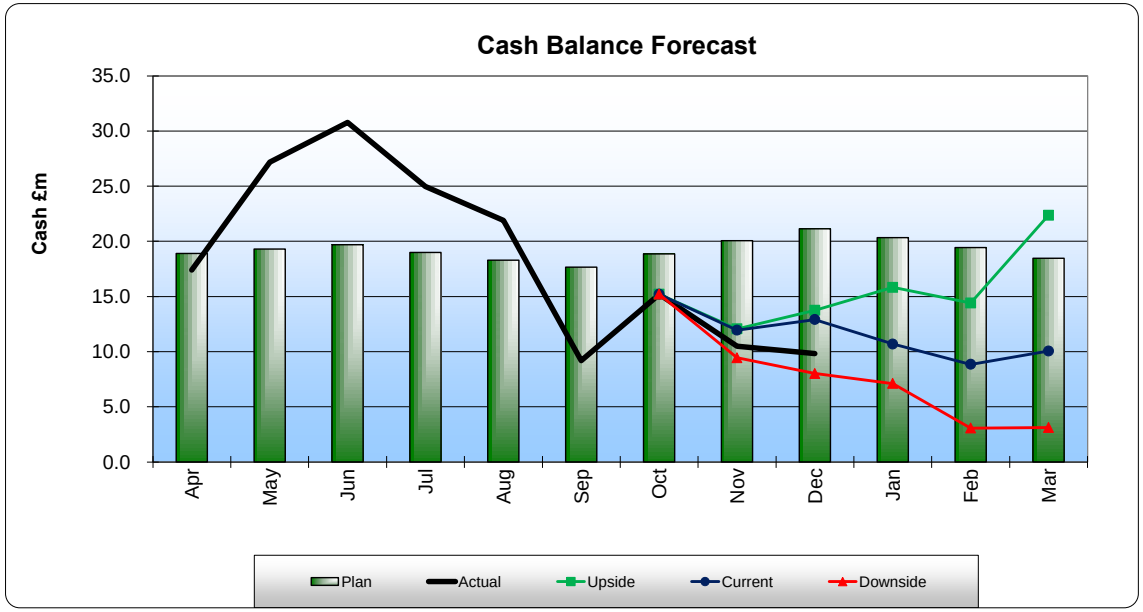


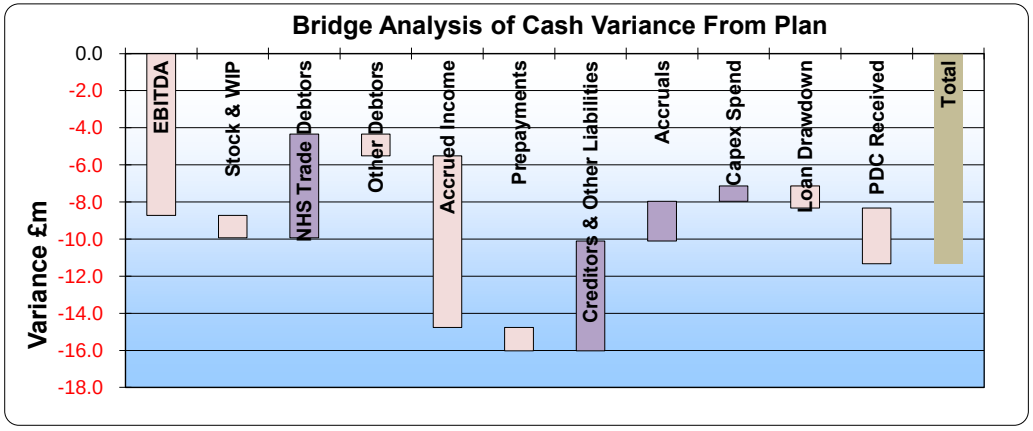
Cash Flow Management
Month 9 - The Period 1st April 2015 to 31st December 2015

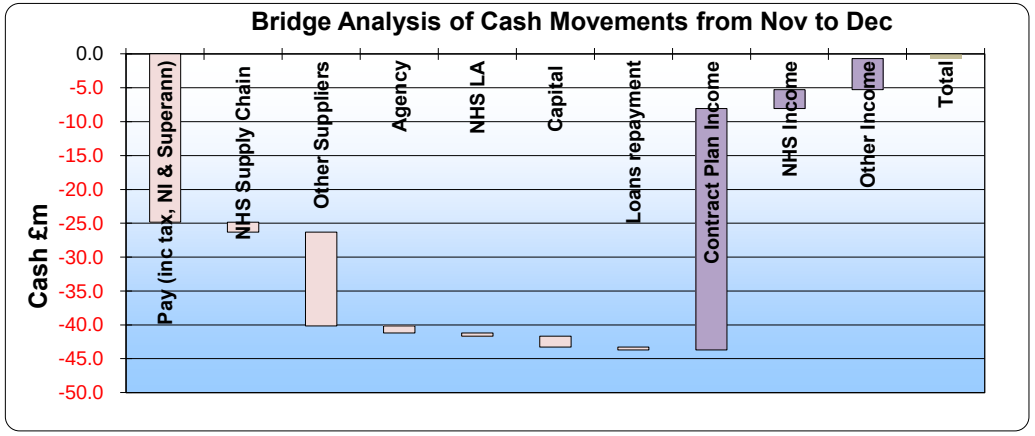
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The cash position at the end of December was £9.8m. This is below plan due to expenditure pressures and is reflective of the I&E position.
* The current cash forecast for future periods has been revised to reflect the current deficit position as we continue to manage our debtors and creditors to maintain control over cash.







Cash Flow Management
Month 9 - The Period 1st April 2015 to 31st December 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

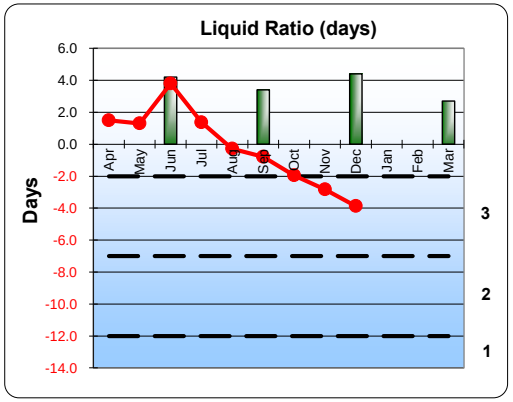
* The receivables balance at the end of December was £8.24m, which is below plan due to continued improvements with debt collection procedures.
* The payables balance at the end of December was £11.64m, which is slightly above plan.
* The Financial Sustainability Risk Rating (FSRR), which is assessed as a score of 2 in December, and is reflective of the I&E position.

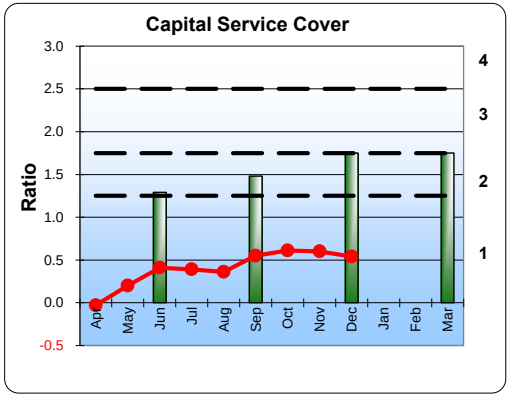
Significant Aged Debtors (+6mths)

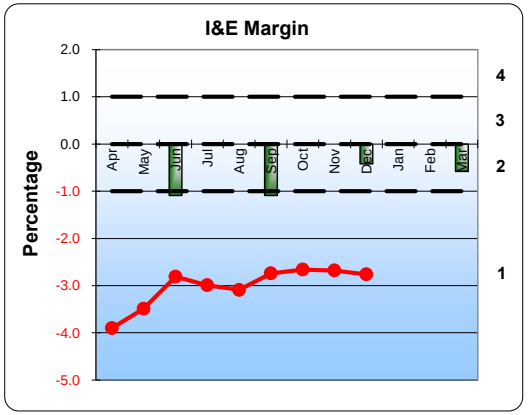
Harrogate and District NHS FT	**£626K**
NHS Vale of York CCG	**£157K**
Leeds and York Partnership NHS FT	**£67K**

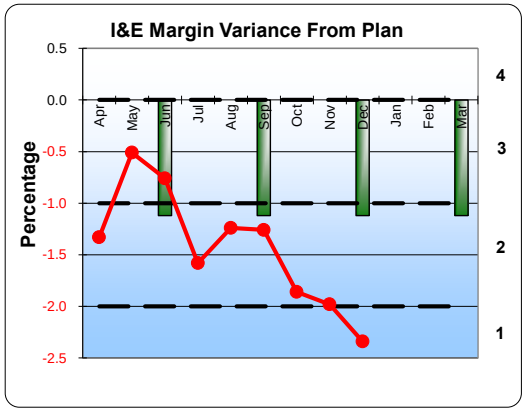
	Under 3 mths £m	3-6 mths £m	6-12 mths £m	12 mths + £m	Total £m
Payables	9.67	0.67	0.98	0.33	11.64
Receivables	6.95	0.13	0.43	0.73	8.24

FSRR Area of Review	Plan for Year	Plan for Year-to-date	Actual Year-to-date	Forecast for Year
Liquidity (25%)	4	4	3	3
Capital Service Cover (25%)	2	1	1	1
I&E Margin (25%)	2	1	1	1
I&E Margin Variance From Plan (25%)	2	2	1	1
Overall Financial Sustainability Risk Rating	3	2	2	2







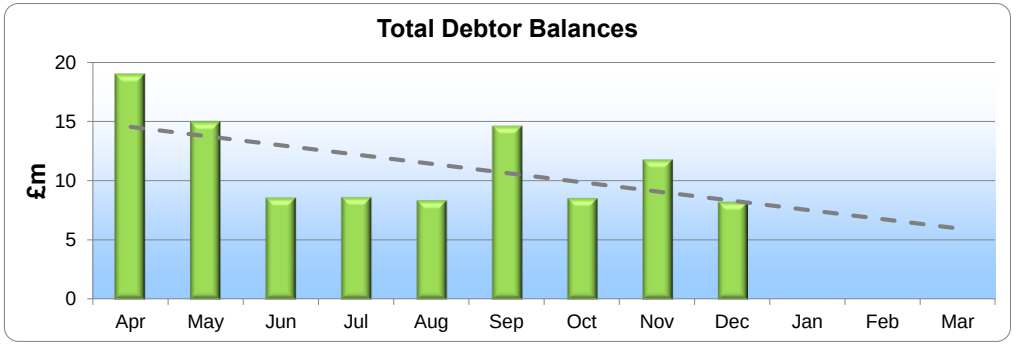


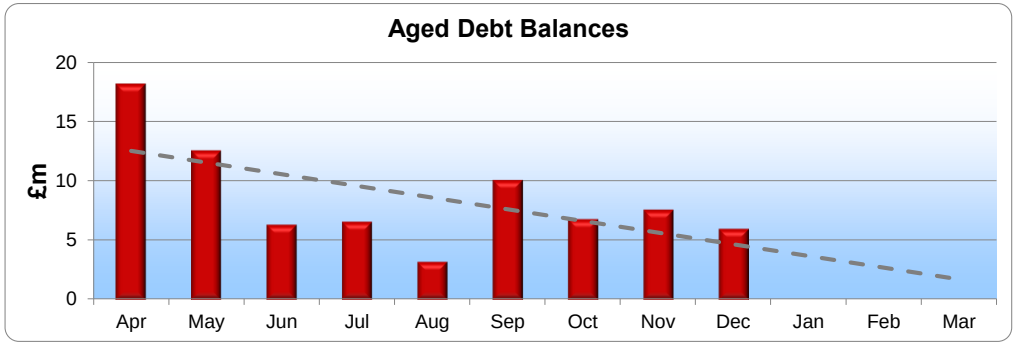
Debtor Analysis
Month 9 - The Period 1st April 2015 to 31st December 2015

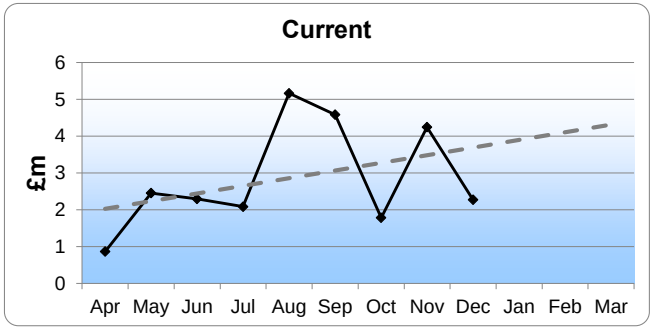
York Teaching Hospital NHS
NHS Foundation Trust

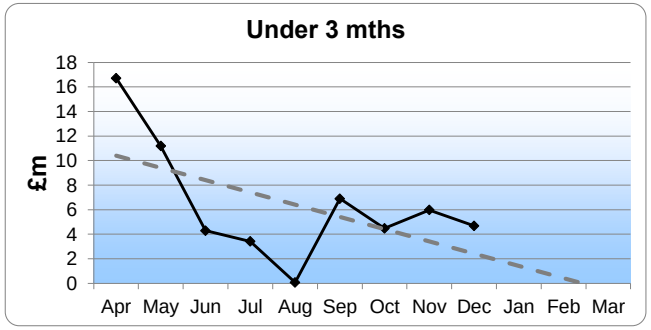
Key Messages:

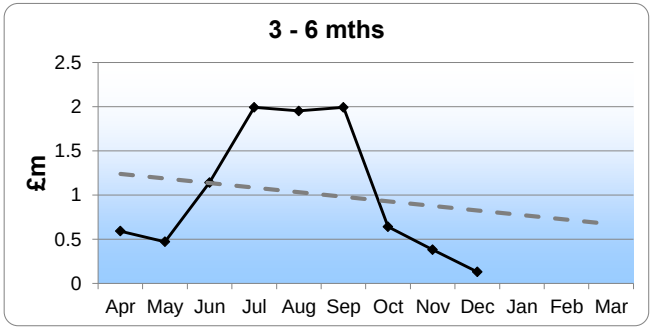
* This new page communicates the ongoing work with the Trust debtors and demonstrates the reduction of aged debts over recent months.
* At the end of September the aged debt balance was £10m and ongoing work has reduced this to £6m at the end of December.
* Total debtor balances are analysed in terms of the age of the invoices and mid-range debtors are reducing.
* Debtors over 6 months are lower in value and are currently under review.

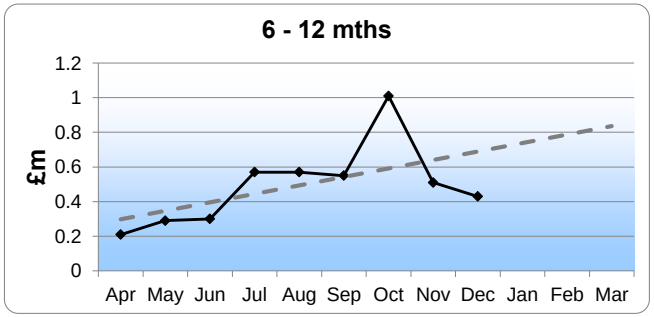


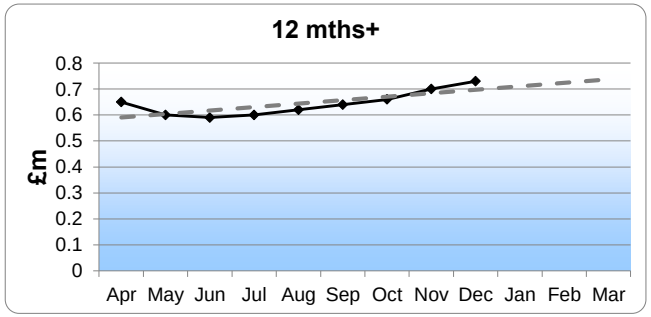












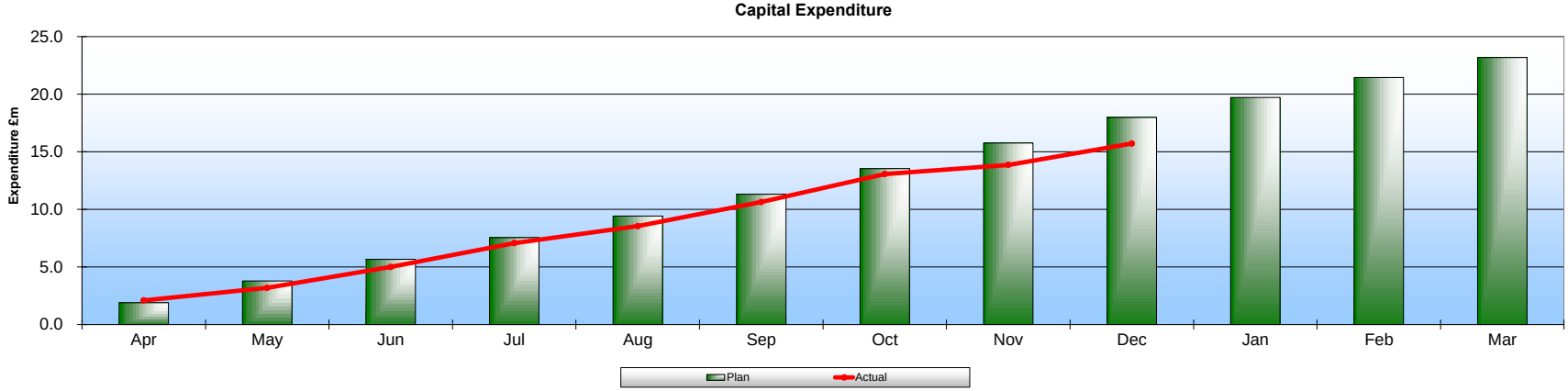
Capital Programme

Month 9 - The Period 1st April 2015 to 31st December 2015

York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* The overall plan has reduced by £2.0m mainly due to part of the Radiology equipment replacement plan moving into next year, therefore the loan funding has moved with it.
* The Capital Programme for December is running slightly behind plan due to the reduction in the forecast outturn as above.
* The Scarborough and Bridlington Carbon Energy Scheme has the largest projected in year spend at £5.187m and is on plan to complete in February 2016.
* Strategic funding has been allocated to existing projects across the Scarborough site, including the Fire Alarm and Lift replacement projects and the upgrade of the IT network.



Scheme	Approved in-year Expenditure	Year-to-date Expenditure	Forecast Outturn Expenditure	Variance	Comments
	£000	£000	£000	£000	
CT Scanner replacement- York (Owned)	2,015	1,715	1,715	300	
Fire Alarm System SGH	440	281	440	0	
York ED Phase 2	1,264	422	1,114	150	
SGH/ Brid Carbon & Energy Project	5,087	4,871	5,187	-100	
Radiology Equipment Upgrade	3,085	21	480	2,605	£900k funded by loan and remainder funded through depreciation/strategic funding
IT Wireless Upgrade - Trustwide	1,400	820	1,400	0	
Other Capital Schemes	3,655	3,007	4,475	-820	
SGH Estates Backlog Maintenance	1,000	614	790	210	
York Estates Backlog Maintenance - York	1,000	1,091	1,091	-91	
Medical Equipment	650	579	650	0	
IT Capital Programme	1,500	811	1,160	340	
Capital Programme Management	1,150	1,020	1,300	-150	
Radiology Lift Replacement SGH	440	40	440	0	
York Endoscopy Phase 1&2	-	168	390	-390	
Urology Facilities Malton	-	249	500	-500	
Contingency	500	-	-	500	Contingency funding has been allocated to specific projects
TOTAL CAPITAL PROGRAMME	**23,186**	**15,709**	**21,132**	**2,054**	

This Years Capital Programme Funding is made up of:-	Approved in-year Funding	Year-to-date Funding	Forecast Outturn	Variance	Comments
	£	£	£	£	
Depreciation	9,614	7,444	9,614	-	
Loan Funding b/fwd	1,386	1,386	1,386	-	
Loan Funding	9,577	5,200	7,172	2,405	
Charitable Funding	739	177	739	-	
Strategic Capital Funding	1,870	1,502	2,221	- 351	
TOTAL FUNDING	**23,186**	**15,709**	**21,132**	**2,054**	

Efficiency Programme

Month 9 - The Period 1st April 2015 to 31st December 2015

York Teaching Hospital NHS
NHS Foundation Trust

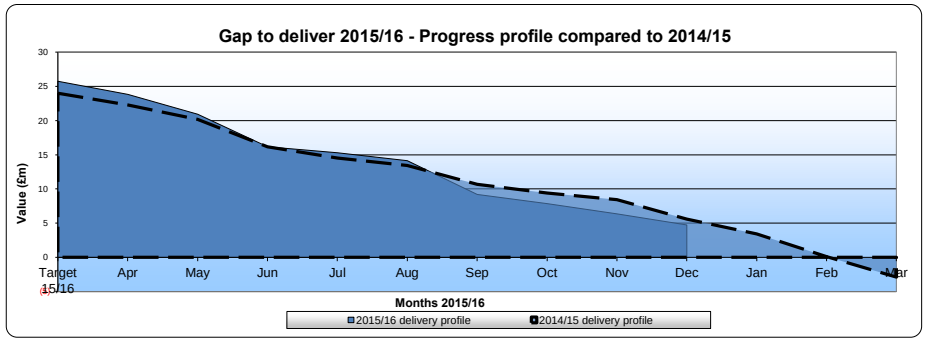
Key Messages:

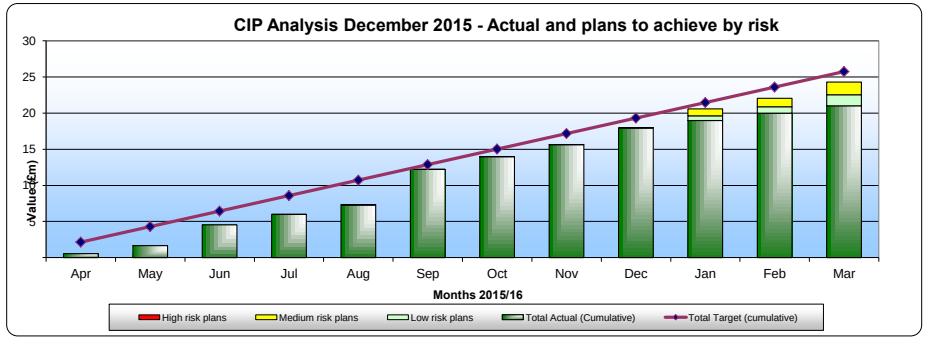
* Delivery - £21m has been delivered against the Trust annual target of £25.8m, giving a shortfall of (£4.7m).
* Part year Monitor variance - The part year Monitor variance has a shortfall of (£1.4m).
* In year planning - The in year planning gap is currently (£1.5m). In Q3 we exclude all in year high risk plans.
* Four year planning - The four year planning gap is (£15.1m).
* Recurrent delivery - Recurrent delivery is £10.2m, which is 40% of the 2015/16 CIP target.

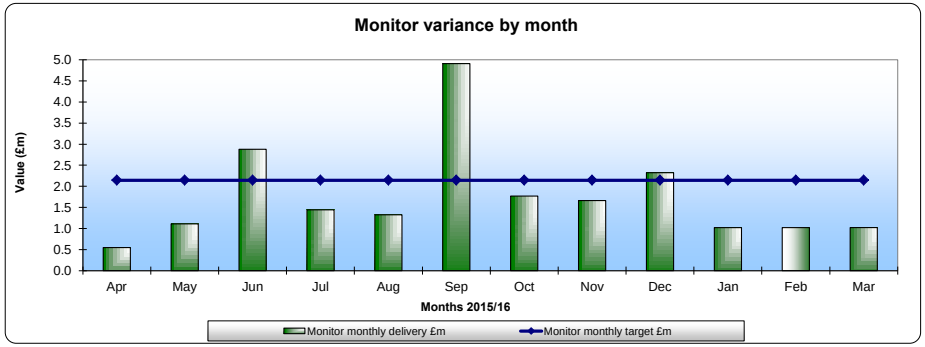
Executive Summary - December 2015	Total £m
TARGET	
In year target	25.8
DELIVERY	
In year delivery	21.0
In year delivery (shortfall)/Surplus	-4.7
Part year delivery (shortfall)/surplus - monitor variance	-1.4
PLANNING	
In year planning surplus/(gap)	-1.5
FINANCIAL RISK SCORE	
Overall trust financial risk score	(2 - RED/AMBER)

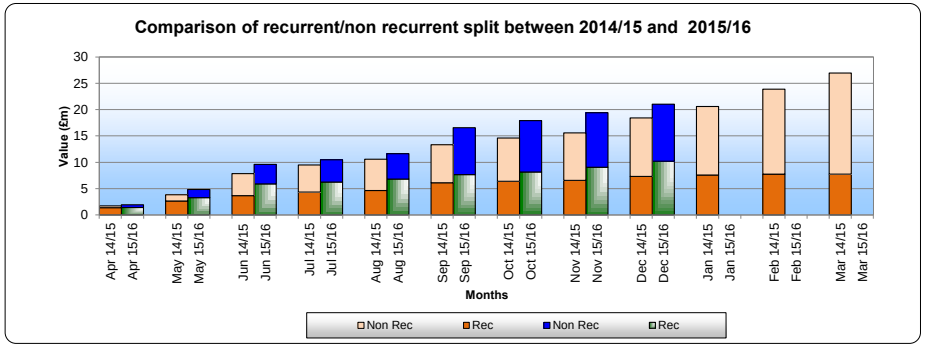
4 Year Efficiency Plan - December 2015					
Year	2015/16	2016/17	2017/18	2018/19	**Total**
	£m	£m	£m	£m	**£m**
Base Target	25.8	15.3	15.2	15.2	**71.4**
Plans	24.3	18.0	9.8	4.4	**56.4**
Variance	-1.5	2.7	-5.4	-10.8	**-15.1**
%	**94%**	**118%**	**64%**	**29%**	**79%**

Risk Ratings			
Financial			
Score	November	December	Trend
1	14	13	↓
2	4	2	↓
3	3	6	↑
4	4	3	↓
5	1	2	↑
Governance			
Score	November	December	Trend
Red	0	0	→
Green	26	26	→







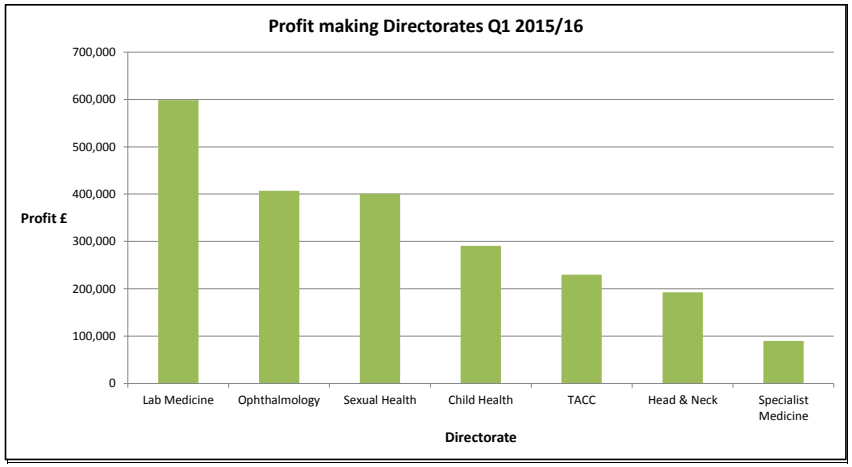


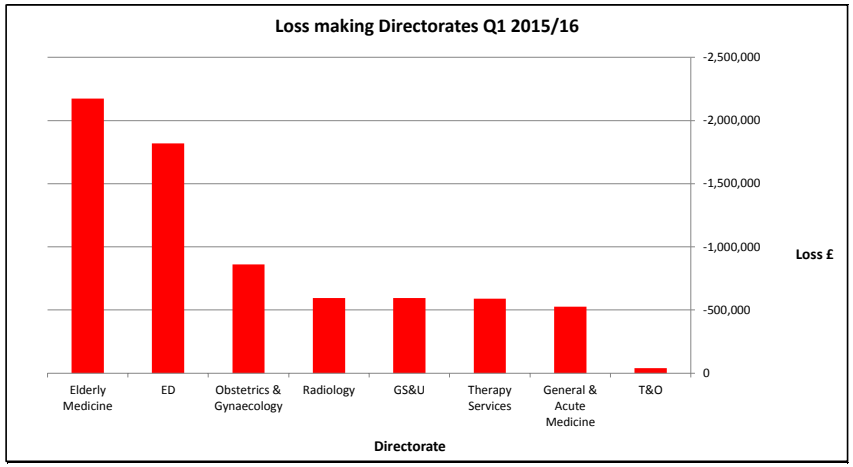
Service Line Reporting
Month 9 - The Period 1st April 2015 to 31st December 2015

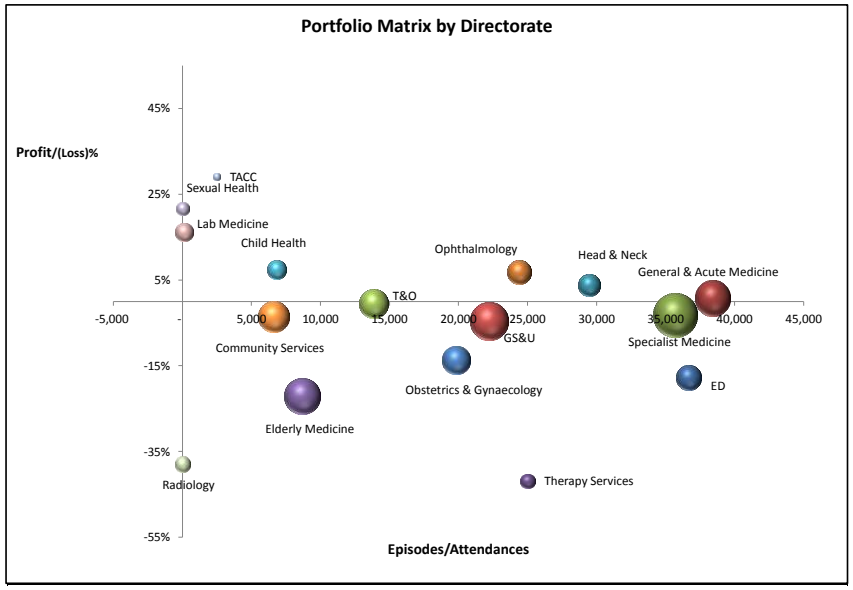
York Teaching Hospital NHS
NHS Foundation Trust

Key Messages:

* Current data is based on Q1 2015/16
* It is expected Q2 2015/16 will be completed towards the end of January 2016
* Directorate teams are being asked to confirm that the correct consultant job plan allocations are used within the SLR system
* Deep dive work is continuing within a number of Directorates
* 2 staff have been appointed to the team - 1 started in September 2015 and the other started on 4th January 2016







DATA PERIOD	FULL YEAR 2014/15
CURRENT WORK	* Q2 2015/16 SLR data is now the key focus following the publication of Q1 data. Q2 2015/16 is expected to be completed towards the end of January 2016 * A detailed deep dive piece of work is currently in progress for Women's Health with the aim of identifying what the true underlying financial position of the service is * Deep dive work for Child Health, Elderly Medicine, General & Acute Medicine, Emergency Medicine and TACC is underway to agree the income and expenditure allocation methods * Work with Directorate teams is currently on-going to improve the quality of consultant job plan allocations used within the SLR system for each quarterly reporting period
FUTURE WORK	* Q3 2015/16 SLR data will be the priority following the completion of Q2 * The SLR team are continuing to work with Directorate teams to improve the quality of outpatient staffing group costs within SLR * Future work around junior doctor job plans will become a key focus to improve the quality of the SLR data and also to inform the annual mandatory Education & Training cost collection exercise *Preparatory work for the Reference Cost and Education & Training mandatory submissions will soon begin ahead of the July and August submission deadlines

BENEFITS TAKEN SINCE SYSTEM INTRODUCTION	**£2.6m**

Executive Pack

December 2015

York Teaching Hospital NHS
NHS Foundation Trust

Executive Summary	Inpatient Elective				Inpatient Non-Elective				Inpatient Day Case				Outpatient (1st Att)				Outpatient (Sub Att)				Non Face-To-Face				Outpatient Procedures			
Specialty	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var	Year Plan	YTD Plan	YTD Actual	YTD Var
Accident And Emergency	0	0	0	0	2910	2174	2447	273	0	0	6	6	945	709	191	-518	818	614	79	-535	0	0	0	0	0	0	0	0
Acute Medicine	0	0	4	4	219	164	672	508	92	69	179	110	774	581	846	265	1004	753	849	96	94	71	24	-47	0	0	0	0
Anaesthetics	54	41	34	-7	17	13	24	11	1750	1313	1482	169	1650	1238	1455	217	2466	1850	2212	362	0	0	0	0	24	18	98	80
Cardiology	670	503	210	-293	2841	2122	1827	-295	1098	824	954	130	12125	9094	10081	987	19537	14654	11739	-2915	155	116	271	155	5627	4221	4074	-147
Chemical Pathology	0	0	0	0	0	0	2	2	54	41	34	-7	50	38	96	58	82	62	264	202	0	0	0	0	0	0	0	0
Clinical Neuro-Physiology	0	0	0	0	0	0	0	0	0	0	0	0	1254	941	923	-18	70	53	66	13	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	8	6	2	-4	365	274	72	-202	7292	5469	4267	-1202	16299	12225	10952	-1273	424	318	49	-269	15441	11581	14982	3401
Ear, Nose And Throat	748	561	567	6	998	745	760	15	952	714	932	218	7810	5858	5639	-219	8307	6231	7266	1035	12	9	24	15	8987	6741	7028	287
Endocrinology	8	6	4	-2	3698	2762	2195	-567	482	362	335	-27	2203	1652	1495	-157	7137	5353	5441	88	506	380	20	-360	0	0	1	1
Gastroenterology	229	172	172	0	4581	3422	4001	579	9602	7202	6923	-279	6261	4696	3566	-1130	11532	8650	6387	-2263	1026	770	824	54	60	45	52	7
General Medicine	5	4	8	4	474	334	452	118	2921	2164	1907	-257	92	69	61	-8	133	100	18	-82	18	14	8	-6	79	59	34	-25
General Surgery	2885	2164	2005	-159	7258	5421	5335	-86	10703	8028	7703	-325	15154	11362	11437	75	23074	17283	15202	-2081	794	596	561	-35	3999	2999	2559	-440
Genito-Urinary Medicine	0	0	0	0	0	0	0	0	0	0	0	0	25550	18362	13491	-4871	11980	8607	7445	-1162	0	0	0	0	0	0	0	0
Geriatric Medicine	6	5	12	7	9421	7037	7885	848	172	129	126	-3	3844	2883	3052	169	3851	2888	2602	-286	941	706	179	-527	46	35	38	3
Gynaecology	822	617	646	29	980	732	904	172	1474	1106	1135	29	7670	5753	5675	-78	5650	4238	4672	434	0	0	1	1	4761	3571	3172	-399
Haematology (Clinical)	42	32	32	0	156	117	168	51	3672	2754	3088	334	1898	1424	1445	21	12610	9458	9929	471	668	501	448	-53	126	95	32	-63
Maxillofacial Surgery	352	264	236	-28	378	282	317	35	1951	1463	1815	352	7009	5257	5425	168	8372	6279	6561	282	0	0	0	0	1846	1385	2120	735
Medical Oncology	58	44	35	-9	148	111	110	-1	6952	5214	5985	771	4186	3140	3194	54	22970	17229	18622	1393	25582	19188	15285	-3903	90	68	103	35
Nephrology	72	54	81	27	1606	1200	839	-361	784	588	614	26	791	593	554	-39	8311	6234	5247	-987	3714	2786	2789	3	0	0	0	0
Neurology	14	11	5	-6	132	99	137	38	746	560	642	82	3286	2465	2167	-298	6115	4587	4022	-565	910	683	574	-109	56	42	0	-42
Obstetrics & Midwifery	24	18	33	15	5338	3987	4364	377	0	0	0	0	46	35	32	-3	1166	875	864	-11	0	0	0	0	168	126	80	-46
Ophthalmology	251	188	212	24	86	64	47	-17	5385	4039	4589	550	16145	12110	11334	-776	57783	43340	39080	-4260	0	0	0	0	12929	9697	8867	-830
Orthodontics	0	0	0	0	0	0	0	0	0	0	0	0	1491	1118	979	-139	1886	1415	1288	-127	0	0	0	0	9636	7227	6610	-617
Paediatrics	65	49	44	-5	7156	5345	6041	696	214	161	235	74	5294	3970	3939	-31	10210	7654	7568	-86	424	318	303	-15	670	503	521	18
Palliative Medicine	0	0	0	0	0	0	0	0	0	0	0	0	1048	786	334	-452	3938	2954	1463	-1491	418	314	193	-121	0	0	0	0
Plastic Surgery	34	26	31	5	8	6	6	0	338	254	323	69	407	305	454	149	512	384	456	72	0	0	1	1	29	22	13	-9
Restorative Dentistry	0	0	0	0	0	0	0	0	0	0	0	0	629	472	566	94	441	331	297	-34	0	0	0	0	1619	1214	935	-279
Rheumatology	6	5	2	-3	14	10	4	-6	2160	1620	1783	163	2732	2049	2049	0	13097	9823	11253	1430	1254	941	1093	152	0	0	0	0
Thoracic Medicine	86	65	57	-8	3611	2697	2635	-62	498	374	408	34	3859	2894	2347	-547	10544	7909	6951	-958	134	101	95	-6	296	222	158	-64
Trauma And Orthopaedic Surgery	1824	1368	1444	76	3258	2433	2459	26	2283	1712	1886	174	18700	14026	14231	205	27248	20437	21403	966	0	0	0	0	1460	1095	1083	-12
Urology	1566	1175	1259	84	1598	1194	1251	57	5844	4383	7231	2848	2662	1997	3950	1953	4243	3182	7144	3962	14	11	30	19	3788	2841	218	-2623
Obstetrics & Midwifery Zero Tariff	0	0	0	0	6332	4730	4987	257	0	0	0	0	8090	6068	6861	793	35308	26483	20709	-5774	0	0	0	0	9460	7095	7430	335
Gynaecology Zero Tariff	4	3	1	-2	362	270	245	-25	2	2	2	0	4	3	1	-2	42	32	23	-9	0	0	0	0	20	15	12	-3
Total	**9825**	**7369**	**7134**	**-235**	**63588**	**47476**	**50116**	**2640**	**60494**	**45346**	**50389**	**5043**	**170951**	**127415**	**122137**	**-5278**	**336736**	**252162**	**238074**	**-14088**	**37088**	**27818**	**22772**	**-5046**	**81217**	**60917**	**60220**	**-697**

F2

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Efficiency Programme Update – December 2015

Action requested/recommendation

The Committee is asked to note the December 2015 position.

Summary

This report provides a detailed overview of progress to date regarding delivery of the Trust's Efficiency Programme. The 2015/16 target is £25.8m and year to date delivery, as at December 2015, is £21.0m.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	This report is presented to the Board of Directors and Finance & Performance Committee.
Risk	The Efficiency Programme presents a significant financial risk to the organisation.
Resource implications	The aim of this work stream is to ensure the most effective use of the Trust resources.
Owner	Andrew Bertram, Director of Finance
Author	Steve Kitching, Head of Corporate Finance & Resource Management
Date of paper	January 2016
Version number	Version 1

York Teaching Hospital NHS
NHS Foundation Trust

Briefing note for the Finance & Performance Committee Meeting 19th January 2016
Briefing note for the Board of Directors Meeting 27th January 2016

Subject: December 2015 - Efficiency Position
From: Steven Kitching, Head of Corporate Finance & Resource Management

Summary reported position for December 2015

Current position – highlights

Delivery - Overall delivery is £21.0m in December 2015 which is (81%) of the £25.8m annual target; there has been a £1.6m improvement in the position in the month. This position compares to a delivery position of £18.4m (65%) in December 2014.

The month 9 part year adverse variance is (£1.4m) which has improved marginally in the month by (£0.1m). This position is ahead of the 2014/15 position which was (£2.0m) adverse.

The relative Directorate positions are shown in Appendix 1 & 2 attached.

In year planning – There remains an in-year planning gap of (£1.5m) at December 2015, this has improved significantly in the month by £1.4m; this is currently a key focus of the team. This position is however better than the comparative 2014/15 position by £0.8m.

Four year planning – The four year planning gap is (£15.1m); this position has improved in the month by £0.9m. The comparative position in December 2014 was a gap of (£17.1m). We have a strong planning position for years 1&2 of the plan with £42.3m (103%) worth of plans identified against a target of £41.1m.

Recurrent vs. Non recurrent – Of the £21m delivery, £10.2m (48.5%) has been delivered recurrently; of the £1.6m delivery in the month, £1.2m was recurrent which is extremely positive. Recurrent delivery is £2.9m ahead of the same position in December 2014, which remains encouraging at this stage. The work continues to identify recurrent schemes.

Quality Impact Assessments (QIA) – All schemes have been sent out to Directorate teams to self assess for their safety impact and all have now been completed. It should be noted that 22 schemes, of the total 909 schemes, were self-assessed as extreme or high risk, following the review process with Helen Hey, Deputy Chief Nurse, 5 of these schemes have been reduced to below high risk. Clinical review continues. Mr Khafagy, Consultant Urologist, has also agreed to provide a medical overview of the process.

Overview

Although delivery in month was lower than anticipated the overall delivery position remains positive with delivery ahead of last year by £2.6m, at £21.0m. The in-year planning position has improved significantly in month by £1.4m; and is £0.8m ahead of 2014/15. The 4 year planning gap is (£15.1m) showing an improvement in month of £0.9m. We currently have plans for 103% of the combined year 1&2 target.

This would indicate that the planning position remains stable.

Recurrent delivery remains relatively strong, with the percentage recurrent delivery at 48.5% of overall delivery which is positive, and positively 75% of in month delivery (1.2m) was recurrent.

All Directorates have self assessed their schemes as part of the QIA self-assessment process, and clinical reviews are well underway.

The majority of Efficiency panels meetings have now taken place. The panels have focused on in year planning and delivery gaps.

Risks

Given the positive position after 9 months, there remain key risks in the programme.

- There is an in-year planning gap of (£1.5m), work continues to close this gap; there is a 4 year planning gap of (£15.1m).
- Recurrent delivery remains a key focus.
- There are 17 schemes which have been rated as extreme or high risk following the self-assessment process; however the senior nursing review continues. Following final reviews a report is to be prepared for the Resource Management Executive Group at the end of January 2016.

RISK SCORES - DECEMBER 2015 -APPENDIX 1

DIRECTORATE	FINANCE						GOVERNANCE	
	R	RA	A	AG	G	Trend	R	G
WOMENS HEALTH	1	2	3	4	5	→	○	●
TACC	1	2	3	4	5	→	○	●
GEN MED SCARBOROUGH	1	2	3	4	5	→	○	●
EMERGENCY MEDICINE	1	2	3	4	5	→	○	●
RADIOLOGY	1	2	3	4	5	→	○	●
SPECIALIST MEDICINE	1	2	3	4	5	→	○	●
COMMUNITY	1	2	3	4	5	↓	○	●
GS&U	1	2	3	4	5	→	○	●
OPHTHALMOLOGY	1	2	3	4	5	↓	○	●
HEAD AND NECK	1	2	3	4	5	→	○	●
CHILD HEALTH	1	**2**	3	4	5	↑	○	●
MEDICINE FOR THE ELDERLY	1	**2**	3	4	5	↑	○	●
SEXUAL HEALTH	1	2	**3**	4	5	↑	○	●
GEN MED YORK	1	2	**3**	4	5	→	○	●
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1	2	**3**	4	5	↑	○	●
LAB MED	1	2	3	**4**	5	↑	○	●
ORTHOPAEDICS	1	2	3	4	**5**	↑	○	●
PHARMACY	1	2	3	4	**5**	→	○	●
CORPORATE								
CHIEF NURSE TEAM DIRECTORATE	1	2	3	4	5	→	○	●
OPS MANAGEMENT YORK	1	2	3	4	5	→	○	●
SNS	1	2	3	4	5	→	○	●
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	1	2	**3**	4	5	↑	○	●
MEDICAL GOVERNANCE	1	2	**3**	4	5	→	○	●
ESTATES AND FACILITIES	1	2	**3**	4	5	↑	○	●
FINANCE	1	2	3	**4**	5	→	○	●
CHAIRMAN & CHIEF EXECUTIVES OFFICE	1	2	3	**4**	5	→	○	●
TRUST SCORE	1	**2**	3	4	5	↑		

RISK SCORES - DECEMBER 2015 - APPENDIX 2

DIRECTORATE	Yr1 Target (£000)	4Yr Target (£000)	Yr 1 Plan v Target		Yr 1 Delivery v Target		Y1 Recurrent Delivery v target		4 Yr Plan v Target		Risk Score	
			%	Score	%	Score	%	Score	%	Score	Total Score	Monitor Rating
WOMENS HEALTH	2,239	4,041	32%	1	17%	1	7%	1	66%	1	4	1
TACC	2,959	7,175	56%	1	33%	1	24%	1	42%	1	4	1
GEN MED SCARBOROUGH	1,150	2,475	52%	1	42%	1	35%	1	53%	1	4	1
EMERGENCY MEDICINE	1,126	2,463	46%	1	42%	1	42%	1	42%	1	4	1
RADIOLOGY	2,410	4,020	53%	1	44%	1	27%	1	43%	1	4	1
SPECIALIST MEDICINE	2,884	6,704	55%	1	50%	1	28%	1	64%	1	4	1
COMMUNITY	1,562	4,007	71%	1	41%	1	28%	1	117%	4	7	1
GS&U	2,087	5,273	106%	3	63%	2	33%	1	70%	1	7	1
OPHTHALMOLOGY	870	2,438	99%	2	63%	2	49%	2	51%	1	7	1
HEAD AND NECK	625	1,833	108%	3	66%	2	26%	1	62%	1	7	1
CHILD HEALTH	1,335	2,870	89%	1	71%	3	50%	3	74%	1	8	2
MEDICINE FOR THE ELDERLY	1,424	3,723	100%	2	92%	5	27%	1	87%	1	9	2
SEXUAL HEALTH	470	1,040	101%	3	84%	4	10%	1	112%	4	12	3
GEN MED YORK	1,949	5,235	99%	2	83%	4	61%	4	118%	4	14	3
AHP & PSYCHOLOGICAL MEDICINE DIRECTORATE	1,612	3,700	125%	5	109%	5	62%	4	86%	1	15	3
LAB MED	1,144	3,247	128%	5	121%	5	78%	5	92%	2	17	4
ORTHOPAEDICS	1,354	3,646	191%	5	171%	5	57%	4	126%	5	19	5
PHARMACY	-189	503	140%	5	101%	5	101%	5	245%	5	20	5
CORPORATE												
CHIEF NURSE TEAM DIRECTORATE	378	695	69%	1	37%	1	15%	1	37%	1	4	1
OPS MANAGEMENT YORK	695	1,090	92%	2	33%	1	0%	1	89%	1	5	1
SNS	1,117	2,139	79%	1	68%	2	34%	1	62%	1	5	1
WORKFORCE AND ORGANISATIONAL DEVELOPMENT	768	1,536	107%	3	89%	4	47%	2	109%	3	12	3
MEDICAL GOVERNANCE	103	222	181%	5	181%	5	18%	1	85%	1	12	3
ESTATES AND FACILITIES	3,088	7,650	91%	2	81%	4	50%	3	115%	4	13	3
FINANCE	151	890	340%	5	340%	5	163%	5	58%	1	16	4
CHAIRMAN & CHIEF EXECUTIVES OFFICE	18	407	1753%	5	1753%	5	965%	5	79%	1	16	4
TRUST SCORE	**33,331**	**79,022**	**94%**	**2**	**82%**	**4**	**40%**	**1**	**79%**	**1**	**8**	**2**

Public Performance Report

January 2016

Our ultimate objective To be trusted to deliver safe, effective and sustainable healthcare within our communities.

Access Targets: 18 Weeks

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Incomplete Pathway: Percentage of patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	**Specialty fail:** £300 fine per patient below performance tolerance **Quarterly:** 1 Monitor point TBC	**92%**	92.5%	92.8%	93.8%	93.6%	94.2%	94.7%	93.6%
Zero tolerance RTT waits over 52 weeks for incomplete pathways	£5,000 per Patient with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	**0**	2	3	0	0	0	0	0
Admitted Pathway: Percentage of admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	80.7%	75.6%	76.3%	77.8%	75.1%	76.7%	82.1%
Non Admitted Pathway: Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from Referral	Nil	**Not a 2015/16 target**	95.4%	95.2%	95.1%	95.4%	95.3%	95.5%	95.3%

Access Targets: Cancer

NB: Cancer Figures Run One Month Behind Due to National Reporting Timescales

Indicator	Consequence of Breach	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Sep	Oct	Nov
14 Day Fast Track	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	89.8%	93.9%	91.9%	one month behind	91.5%	95.1%	94.8%
14 Day Breast Symptomatic	**Quarterly:** £200 fine per patient below performance tolerance 0.5 Monitor point TBC	**93%**	91.0%	91.4%	94.0%	one month behind	95.2%	95.1%	92.4%
31 Day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**96%**	96.1%	96.2%	99.3%	one month behind	100.0%	99.6%	99.1%
31 Day Subsequent Treatment (surgery)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**94%**	95.6%	94.4%	97.3%	one month behind	97.6%	96.0%	92.3%
31 Day Subsequent Treatment (anti cancer drug)	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point TBC	**98%**	98.5%	99.6%	100.0%	one month behind	100.0%	100.0%	100.0%
62 day 1st Treatment	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**85%**	76.5%	87.8%	85.1%	one month behind	85.4%	79.9%	83.0%
62 day Screening	**Quarterly:** £1000 fine per patient below performance tolerance 0.5 Monitor point tbc	**90%**	92.2%	98.4%	92.0%	one month behind	92.3%	94.7%	100.0%
62 Day Consultant Upgrade	General Condition 9	**85%**	50.0%	-	-	-	-	-	-

Emergency Department

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Percentage of A & E attendances where the Patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	£120 fine per patient below performance tolerance (maximum 10% breaches) **Quarterly**: 1 Monitor point TBC	**95%**	89.1%	88.3%	91.5%	87.1%	87.3%	84.6%	89.3%
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	£200 per patient waiting over 30 minutes in the relevant month	**0 > 30min**	520	539	315	336	102	111	123
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	£1,000 per patient waiting over 60 minutes in the relevant month	**0 > 60min**	383	415	139	190	63	68	59
Ambulance Handovers over 30 and 60 Minutes by CCG	**Ambulance Handovers over 30 and 60 Minutes by CCG**	**Breach Category**	**Q4 14/15**	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**	**Oct**	**Nov**	**Dec**
	NHS VALE OF YORK CCG	30mins - 1hr	161	163	88	91	24	42	25
		1hr 2 hours	109	114	47	74	19	40	15
		2 hours +	44	26	19	18	8	6	4
	NHS SCARBOROUGH AND RYEDALE CCG	30mins - 1hr	177	152	94	127	41	37	49
		1hr 2 hours	83	101	28	42	18	8	16
		2 hours +	25	28	1	7	3	2	2
	NHS EAST RIDING OF YORKSHIRE CCG	30mins - 1hr	134	146	82	86	24	21	41
		1hr 2 hours	70	76	23	36	11	10	15
		2 hours +	17	22	1	4	0	1	3
	NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	30mins - 1hr	20	27	13	10	6	1	3
		1hr 2 hours	15	14	6	2	2	0	0
		2 hours +	2	3	0	0	0	0	0
	NHS HARROGATE AND RURAL CCG	30mins - 1hr	6	1	1	0	0	0	0
		1hr 2 hours	0	0	1	0	0	0	0
		2 hours +	0	0	0	0	0	0	0
	OTHER	30mins - 1hr	22	50	37	22	7	10	5
		1hr 2 hours	12	27	12	6	2	1	3
		2 hours +	6	4	1	1	0	0	1
Total number of patients waiting over 8hrs in A&E	General Condition 9	Q1 - Establish baseline	944	732	431	1060	354	442	264
Trolley waits in A&E not longer than 12 hours	£1,000 per incidence in the relevant month	**0 > 12 hrs**	11	0	1	0	13	5	0
Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**95%**	97.6%	97.5%	97.1%	To follow	98.0%	To follow	To follow

Mortality

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Oct 12 - Sep 13	Jan 13 - Dec 13	Apr 13 - Mar 14	Jul 13 - Jun 14	Oct 13 - Sep 14	Jan 14 - Dec 14	Apr 14 - Mar 15
Mortality – SHMI (YORK)	**Quarterly:** General Condition 9	**A banding of "Significantly higher that expected" in SHMI using the "Extract Poisson Distribution" method for deriving upper and lower confidence limits, applied to each sub-group reported**	93	93	95	98	99	97	96
Mortality – SHMI (SCARBOROUGH)	**Quarterly:** General Condition 9		104	105	107	108	109	107	108

Infection Prevention

Indicator	Consequence of Breach (Monthly)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Minimise rates of Clostridium difficile	*Schedule 4 part G* **Quarterly:** 1 Monitor point tbc	**48**	21	21	14	15	5	3	7
Number of Clostridium difficile due to "lapse in care"	Establish baseline and set trajectory	**TBC**	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of E-Coli cases	**Quarterly:** General Condition 9	**108 (TBC)**	27	24	16	23	7	8	8
Number of Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases	**Quarterly:** General Condition 9 (identified in 15/16 contract as HPA MESS monthly)	**30**	13	11	9	10	6	2	2
Zero tolerance MRSA	£10,000 in respect of each incidence in the relevant month	**0**	1	6	0	0	0	0	0
Confirmed cases of MRSA Bacteraemia to be notified to commissioner by next working day	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) of MRSA bacteraemia/SI report to be provided to the commissioner within 21 working days of the case being identified in line with national data capture system	General Condition 9	**100%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Post Infection Review (PIR) completed	TBC	**TBC**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
All High Risk (non-day case) Elective admissions are screened for MRSA prior to admission	**Quarterly:** General Condition 9	**95%**	86.0%	85.1%	85.6%	83.1%	82.3%	79.9%	89.9%
Emergency admissions are screened for MRSA within 24 hours of admission	**Quarterly:** General Condition 9	**95%**	66.2%	72.2%	75.1%	74.5%	71.5%	72.7%	79.7%

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Percentage of Patients waiting less than 6 weeks from Referral for a diagnostic test	£200 fine per patient below performance tolerance	**99%**	95.9%	95.2%	99.4%	99.1%	99.0%	99.5%	99.1%
Sleeping Accommodation Breach	£250 per day per Service User affected	**0**	0	0	2	0	0	0	0
All Patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days	Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care	**0**	15	9	0	0	2	0	0
No urgent operation should be cancelled for a second time	£5,000 per incidence in the relevant month	**0**	0	0	0	0	0	0	0
Cancelled operations within 48 Hours of the TCI due to lack of beds	General Condition 9	**65 per month**	548	205	40	182	77	66	39
VTE risk assessment: all inpatient undergoing risk assessment for VTE, as defined in Contract Technical Guidance	£200 in respect of each excess breach above threshold	**95%**	96.9%	97.1%	97.4%	97.9%	97.2%	98.5%	97.9%
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	£10 fine per patient below performance tolerance	**99%**	99.9%	99.8%	99.7%	To follow	99.8%	To follow	To follow
Failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book System	General Condition 9	**>4% slot unavailability if utilisation >90% >6% unavailability if utilisation <90%**	4.3%	n/a	Reports currently unavailable from the HSCIC due to a change in system.				
All ELECTIVE patients to have an Expected Discharge Date (EDD) recorded in the patient case notes or patient management system within 24 hours of admission	General Condition 9	**Q1 - 87% Q2 - 89% Q3 - 91% Q4 - 93%**	92.0%	89.1%	89.7%	88.7%	88.3%	89.9%	87.8%
Delayed Transfer of Care to be maintained at a minimum level	As set out in General Condition 9 - Trust only to be accountable for Health delays.	**<1%**	1160	1476	1459	1754	560	569	625
Trust waiting time for Rapid Access Chest Pain Clinic	General Condition 9	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
No patient cancelled more than twice by the Trust for non-clinical reasons. All new dates to be arranged within 6 weeks of the cancelled appointment	General Condition 9	**90%**	Annual statement of assurance						
Outpatient clinics cancelled with less than 14 days notice	General Condition 9	**200 per month**	514	452	486	448	164	141	143
Reduction in number of hospital cancelled first and follow up outpatient appointments for non-clinical reasons where there is a delay in the patient treatment	General Condition 9	**End Q2 745; end Q4 721**	2375	2365	2509	2492	876	852	764
% Compliance with WHO safer surgery checklist	General Condition 9	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Readmissions within 30 days – Elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	388	419	460	1 month coding lag	160	109	1 month coding lag
Readmissions within 30 days – Non-elective	The CCG will apply a % penalty following Flex and Freeze validation. (ER)	**08/09 outturn awaiting figure from CCG**	1420	1434	1431	1 month coding lag	467	406	1 month coding lag
Reduction in avoidable transfers within the Trust after 10pm. Excludes transfers for clinical reasons or for patients transferred to a more appropriate ward	General Condition 9	**100 per month (Baseline 374; Q1;-330; Q2-280;Q3-250;Q4-220)**	374	302	258	308	107	110	91

Quality and Safety

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Number/Percentage women who have seen a midwife by 12 weeks and 6 days (as per IPMR definition)	General Condition 9	**90%**	99.3%	99.7%	99.1%	99.7%	99.1%	100.0%	100.0%
Stroke Performance against Sentinel Stroke National Audit Programme (SSNAP)	General Condition 9	**Best Practice Standards**	Quarterly summary of performance against SSNAP indicators as submitted to RCP. Stroke service exception action plan to be produced quarterly .						
Immediate Discharge letters - 24 hour standard: Overall Trust Position Monthly report and quarterly audit . Action plan to be provided where the target failed in any one month. 25 cases from SR and 25 cases from ERY.	General Condition 9	**>98% for admitted patients discharged and >98% for A&E patients discharged**	Quarterly audit						
Quality of Ward IDLs (Quarterly audit undertaken on Scarborough and Rydale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology). 25 cases from SR and 25 cases from ERY	General Condition 9	**Q1 - 94% Q2 - 95% Q3 - 96% Q4 - 97%**	Quarterly audit						
Quality of ED IDLs (Quarterly audit undertaken on Scarborough and Ryedale and East Riding patients and triangulated with Trust information. Method of measurement will be in line with agreed methodology)	General Condition 9	**Q1 - 90% Q2 - 92% Q3 - 94% Q4 - 96%**	Quarterly audit						
All Red Drugs to be prescribed by provider effective from 01/04/2015	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
All Amber Drugs to be prescribed by provider effective from 01/04/2015	Recovery of costs for any breach to be agreed via medicines management committee	**100% list to be agreed**	CCG to audit for breaches						
NEWS within 1 hour of prescribed time	None - Monitoring Only	**None**	85.9%	87.0%	87.4%	86.9%	86.3%	87.1%	87.3%

Never Events

Indicator	Consequence of Breach (Monthly unless specified)	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Never Events	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	**>0**	0	1	0	0	0	0	0

District Nursing Activity Summary

Indicator	Source	Threshold	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Oct	Nov	Dec
Community Adult Nursing Referrals (excluding Allied Health Professionals)	GP	-	2040	2769	2576	3448	1293	1078	1077
	Community nurse/service	-	792	921	886	1058	319	358	381
	Acute services	-	904	1086	961	1151	437	343	371
	Self / Carer/family	-	425	470	662	888	434	182	272
	Other	-	236	309	278	378	136	97	145
	Grand Total	-	4397	5555	5363	6923	2619	2058	2246
Community Adult Nursing Contacts	First	-	3187	4360	4479	5115	1723	1677	1715
	Follow up	-	35421	41534	46925	55714	18837	17881	18996
	Total	-	38608	45894	51404	60829	20560	19558	20711
	First to Follow Up Ratio	-	11.1	9.5	10.5	10.9	10.9	10.7	11.1
Community Hospitals average length of stay (days)	Archways	-	26.8	21.1	23.0	21.3	20.7	23.6	20.3
	Malton Community Hospital	-	16.0	19.9	16.1	17.3	14.2	14.9	23.1
	St Monicas Hospital	-	24.0	15.5	15.5	16.7	16.6	12.5	20.3
	The New Selby War Memorial Hospital	-	17.6	15.3	14.2	13.3	12.1	11.0	16.7
	Whitby Community Hospital	-	21.9	20.0	19.5	12.8	12.3	11.1	18.4
	Total	-	20.2	18.5	17.4	15.5	14.1	13.5	19.7
Community Hospitals admissions. Please note: Patients admitted to Community Hospitals following a spell of care in an Acute Hospital have the original admission method applied, i.e. if patient is admitted as a non-elective their spell in the Community Hospital is also non-elective.	Archways	Elective	5	8	11	11	1	4	6
		Emergency	71	73	79	80	28	20	32
	Malton Community Hospital	Elective	48	19	37	15	2	9	4
		Emergency	110	101	115	128	54	34	40
	St Monicas Hospital	Elective	16	17	14	15	4	5	6
		Emergency	27	43	41	38	18	10	10
	The New Selby War Memorial	Elective	57	59	69	73	30	20	23
		Emergency	55	68	68	72	27	21	24
	Whitby Community Hospital	Elective	0	0	1	1	0	0	1
		Emergency	140	136	133	191	81	76	34
	Total	Elective	126	121	122	115	37	38	40
		Emergency	403	441	508	509	208	161	140

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Complaints and PALS												
New complaints this month	39	37	47	43	41	33	41	37	58	42	38	28
Number of Ombudsman complaint reviews	3	4	7	2	4	1	1	3	1	0	2	1
Late responses this month (at the time of writing)***	4	1	0	3	2	10	7	4	6	0	8	0
Top complaint issues												
Aspects of clinical treatment	21	20	32	30	27	21	29	27	30	15	30	24
Admission/discharge/transfer arrangements	2	3	2	1	3	1	1	1	5	5	2	3
Appointment delay/cancellation - outpatient	1	2	2	2	2	0	1	1	0	2	3	1
Staff attitude	10	7	5	3	7	3	3	3	0	0	0	0
Communications	2	2	4	4	1	3	2	2	8	5	7	9
Other	0	1	0	0	1	1	0	2	0	0	0	0
New PALS queries this month	620	559	478	430	416	498	643	530	631	682	505	450
PALS queries at same time last year	503	470	367	378	369	406	442	488	426	463	392	334
Top PALS issues												
Information & advice	189	173	126	158	155	171	237	233	296	309	202	171
Staff attitude	19	14	12	19	14	23	24	14	19	17	18	13
Aspects of clinical treatment	77	47	84	69	63	72	101	64	76	75	66	53
Appointment delay/cancellation - outpatient	47	28	52	29	35	46	59	39	60	55	49	40

**note: upheld complaints are reported quarterly to allow for investigation timescales*

***note: we do not record partly - if a complaint generates 1 or more actions for improvement then it is recorded as upheld*

****note: if extensions are made in agreement with the complaint, responses are not considered late*

Serious Incidents												
Number of SI's reported	17	16	18	12	14	12	20	11	16	22	19	12
% SI's notified within 48 hours of SI being identified*	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%
% SI's closed on STEIS within 6 months of SI being reported	0%	0%	66%	100%	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Number of Negligence Claims	12	17	15	15	15	12	14	8	14	21	21	15
Extension requests made at least 4 weeks prior to deadline of report due date, and reason given is acceptable to CCG (Threshold - 90% by Q4)				0	2	0	1	0	0	0	0	1
Duty of Candour demonstrated within SI Reports (Threshold 100%)				100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of reported SI's, investigated and closed as per agreed timescales**** (Threshold (90%)				83%	85%	83%	93%	100%	92%	94%	75%	87%
Percentage of reported SI's with extension requested.				0.0%	13.3%	0.0%	6.3%	0.0%	8.3%	10.0%	25.0%	6.7%

* this is currently under discussion via the 'exceptions log'

Monthly Quantitative Information Report

York Teaching Hospital NHS
NHS Foundation Trust

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Pressure Ulcers**												
Number of Category 2	51	35	44	37	49	34	37	44	33	29	48	38
Number of Category 3	4	3	6	4	8	10	4	3	3	7	4	3
Number of Category 4	1	0	1	0	1	0	0	1	1	4	1	1
Total number developed/deteriorated while in our care (care of the organisation) - acute	50	30	41	31	38	35	33	35	27	27	50	38
Total number developed/deteriorated while in our care (care of the organisation) - community	24	25	32	25	47	27	29	28	27	34	33	22
Falls***												
Number of falls with moderate harm	2	2	3	1	2	5	0	3	3	4	2	
Number of falls with severe harm	2	5	4	3	8	4	5	1	5	3	8	
Number of falls resulting in death	0	1	0	0	0	0	1	0	0	1	0	
Safeguarding												
% of staff compliant with training (children)	55%	58%	59%	62%	65%	68%	74%	80%	80%	81%	82%	82%
% of staff compliant with training (adult)	45%	56%	59%	62%	64%	69%	74%	80%	81%	82%	82%	82%
% of staff working with children who have review CRB checks												

Note ** and *** - falls and pressure ulcers subject to validation. Fall resulting in death currently being investigated as Serious Incident and the degree of harm will be confirmed upon completiion of investigation.
All falls and pressure ulcer data has been refreshed to reflect imrovements in identification, monitoring and reporting of falls and pressure ulcers.
**** - data revised to exclude SIs which have been delogged since declaration

Blank page

Workforce Strategy Committee Meeting
8th December 2015

York Teaching Hospital NHS
NHS Foundation Trust

Attendance:

Dianne Willcocks, Non-Executive Director (Chair)
Libby Raper, Non-Executive Director (Vice Chair)
Mike Proctor, Deputy Chief Executive
Gail Dunning, Head of Corporate Development
Jonathan Thow, Deputy Medical Director (Education)
Anne Devaney, Head of Corporate Learning
Beverley Geary, Chief Nurse
Sian Longhorne, Senior HR Lead

Apologies:
Pat Crowley, Chief Executive
Melanie Liley, Head of AHP Services and Psychological Medicine
Polly McMeekin, Deputy Director of Workforce
Wendy Scott, Head of Community Services

	Agenda Item	AFW	Comments	Assurance	Attention to Board
1.0	**Last Meeting Notes Minutes Dated** **Matters arising from October minutes**		**Paper 1** Minutes approved. <u>Health & Wellbeing Programme</u> DW requested an update on what impact it is having. <u>Papers</u> DW commended the papers provided and thanked those presenting	PMc to invite Dawn Preece to next meeting or produce a report. Task & finish group (PMc, AD, GD, MP).	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			that the papers were succinct. A discussion took place about combining a number of documents, which had already been produced including for example, the Education Strategy, into one overarching Workforce Development Strategy. It was agreed this would be brought back to the meeting in March.	To present paper at March meeting.	
2.0	**Terms of Reference**		**Paper 2** DW stated revisions offered coherence and purpose and key roles, with a clear remit for general/planning/strategic activities framework. It aims to avoid duplication with other committees. Terms were approved. The committee debated whether all papers needed to go to both this meeting and to the Board or whether the committee should just report exceptions to Board. The latter was approved.	SL to amend ToR as appropriate.	
3.0	**Community Workforce Development Programme**		Deferred to next meeting.		
4.0	**Workforce Board Report**		**Paper 3** SL gave an overview of the report. <u>Sickness absence</u> Sickness absence has increased this year and the annual rate is currently 3.87%. Part of the increase is related to work to improve the reporting of doctors' absence - historically under reported. There have been increases in a number of staff groups. The Trust's absence rate continues to compare very favourably with other trusts in the region. The committee agreed that it would be useful for conversations to happen outside of the meeting to determine the impact of other work across the organisation on absence rates, e.g. OD interventions	SL to provide report	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			<u>Turnover rate</u> SL reported that turnover amongst registered nursing staff and AHPs is higher than the Trust turnover rate. SL has provided more detail on nursing turnover to the Chief Nursing team already. The committee discussed what the Trust can do to increase retention including enhanced preceptorship and targeted talent management. DW requested more detail on actual numbers of starters and leavers and reasons for leaving. JT mentioned the critical role of AHPs in acute medicine. Agreed the committee need to understand more about issues affecting this group. <u>Pay expenditure</u> SL advised that new rules have been introduced in the past month by Monitor and the Trust has introduced new initiatives to improve the benefits of working on the bank. These have been positively received; there was a reduction in nursing agency spend in November and a significant number of bank applications from substantive staff. DW requested a breakdown of temporary staffing use for nursing, e.g. split between bank shifts, agency shifts and overtime against a priority order for filling vacancies. <u>Staff Survey</u> Final response rate was 45% which was disappointing, although it was similar across the board with the national response rate being 37%. Results will be analysed and benchmarked early next year. <u>The Living Wage</u> MP reported that the CEO is continuing to have discussions and further explore the deliverability and appropriateness of options to be able to pay the Living Wage. LR said that we may need to think radically in how the Trust can deliver the living wage. <u>Appraisal Compliance</u> Medical staffing appraisal compliance was 51.6% JT challenged this.	to next meeting. M. Liley to be asked to produce a paper. SL to include this in the monthly report to Board.	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			He suggested that it may simply be that the final sign off had not been done and there may be a recording issue. DW stipulated that this needs to be recorded correctly when presented to the Board.	SL to check this figure with the MHPS team.	
5.0	**Key Issues in medical establishments**		**Paper 4** JT gave an overview of the paper designed to inform and initiate debate. The paper focussed on the critical role of registrars with benchmarking indicating that numbers at this Trust are significantly lower than in other Trusts. The paper detailed options to address the issues including new part clinical/part leadership roles, seeking funding from external sources, new flexible contracts which would better support part time working. The committee asked for a further update on each of the options at the March meeting and it was agreed the paper would be provided to the Board as an appendix to the committee minutes.		
6.0	**Temporary Workforce Spend**		**Paper 5** This was covered with paper 3 (agenda item 4 above)		
7.0	**Risk matrix**		**Paper 6** The committee had previously agreed that this would be a standing item on the agenda. DW stated that she felt some issues on the matrix need to be prioritised, e.g. recruitment, retention and agency use and asked for it to be re-presented for the next meeting.	PMc to re-present matrix with priorities.	
8.0	**Workforce risk register and Assurance Framework**		**Papers 7 & 8** The revised HR risk register was provided for information. Areas of risks described are covered by activities of the Committee. LR raised a question about the granularity of the detail of the issues and what gives an issue a risk rating of 12.	Papers 6, 7, 8 to be referenced at future meetings	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
9.0	**HR TAP updates**		**Paper 9** Templates with updates on HR linked TAP projects were presented. MP reported on job planning where scrutiny meetings were commencing with directorates - giving assurance to Board that robust job planning is a priority. DW referred to the Senior Management Review TAP project and asked how a more structured approach might create efficiencies at this level. MP noted that all band 7 plus roles receive enhanced scrutiny prior to advertising; the majority are clinical. The committee asked for a fuller update on this plan at the next meeting.	PC to provide update at next meeting.	
10.0	**Educational Partnership**		MP provided a verbal update on discussions with educational establishments. Integration and out of hospital initiatives are going to require a generic workforce. MP has also been engaging with the Chair of the Workforce Group, East Coast, through Ambitions for Health, in developing action to create workforce capability across social care, mental health and acute care. MP has introduced Coventry University to HEE as a potential provider for this education and has engaged with York St. John University which opens up discussions with York College. DW suggesting engaging with Leeds Beckett University/ who have a new VC plus Teesside who have the relevant track record. The committee discussed the principles of 'growing our own workforce', becoming a better employer and showing staff we'll support them to maximise their potential. It was noted that line managers and team leaders must understand the expectations around releasing staff for development. MP was asked to bring a paper on this work, including the letter he will write to Ambitions for Health. The committee would like Wendy Scott to describe the generic worker	MP to provide Workforce paper. WS to describe this at the next meeting	

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			roles when she attends the next meeting.		
11.0	**Summer placements**		**Paper 10** SL gave an overview of the paper and explained that support was being sought from the committee to run the scheme next year. Two schools have already approached to ask if the scheme will run again. DW commended a positive report and agreed that fitting in with school year is essential, in particular that the process should be started before the Easter break. LR suggested engaging students who took part last year in the recruitment and maybe promote next year on social media. AD asked why Scarborough took only one school – this was because of the tight timeframes to get schools involved. LR suggested that the hospital charity could help with funding for the scheme.	HR lead for the scheme to discuss with the charity	
12.0	**Skills & Competency Review**		**Paper 11** Deferred to next meeting.		
13.0	**Organisational Development update**		**Paper 12** GD provided a 6 month update. Whilst the OD team have significantly reduced in size, GD reported that there have been 48 interventions from the team, although some of this might not be formal interventions but could be signposting to other solutions. GD said that some clinical areas struggle to find time to participate in interventions. GD said that across the organisation, efficiencies and cost savings have been identified through the service improvement projects which have been undertaken. LR suggested that we could think more broadly about external partners for mentoring. DW asked for evidence of the benefits of interventions and requested a		

	Agenda Item	AFW	Comments	Assurance	Attention to Board
			report giving qualitative / quantitative figures plus update on leadership, coaching, etc., in one paper for the next 6 monthly report.	GD to provide report update in six months' time.	
14.0	**Education Strategy Update**		**Paper 13** AD presented an updated on the Education Strategy. Of particular note were the following points; Much of the simulation activity is reliant on HEE funds. Stat Mand training compliance is now 81% but this overall figure does not reflect the increase in particular topics which were previously low. ACPs: AD informed that because of difficulties with the current education provider, Hull University, they are looking at alternative providers. BG said that whilst we need to invest in ACPs there are risks relating to the education provider and the potential impact on the band 7 workforce. DW felt it was important to highlight to Board that the process with the external education provider is fragile.		Board to note this and other challenges in links with Education providers
15.0	**Next meeting dates**		**26th January 2016, 08:30 – 10:30** Mtg Room1, 2nd Floor, Park House **15th March 2016, 13:00 – 15:00**, Classroom 4, Post Grad Medical Education Centre, 5th Floor		

Actions Workforce Strategy Committee
Date of Last Meeting - 08.12.15
Last Updated 10.12.15

Agenda Item	Issue	Action	Timescale	Who responsible	Progress
1.0	Minutes of December meeting	To be approved	January	All	
	Matters arising:-				
	Health & Wellbeing Programme	Invite Dawn Preece to next meeting or produce a report	January meeting	PM	
	Workforce Development Strategy	PM to lead on this and discuss with MP, AD and GD. Report back.	March meeting	PM	
2.0	Terms of Reference	SL to amend terms of reference	January meeting	SL	
4.0	Workforce Board Report	Turnover rate - SL to provide analysis on reasons for leaving, numbers leaving and number of starters for registered nursing and AHPs.	January meeting	SL	
		Pay expenditure – SL to provide hierarchical detail on overtime, bank and agency usage.	January meeting	SL	
		Appraisal compliance – check compliance rate for medical staffing is correct.	December reporting	SL	

		Mel Liley to be asked for paper detailing AHP workforce issues	TBA	ML	
9.0	HR TAP updates	Update on Senior Management Review TAP project	January meeting	PC	
10.0	Educational Partnership	Provide workforce paper.	January meeting	MP	
11.0	Summer Placements	Contact YH Charity.	December	HR lead for summer placements	
13.0	Organisational Development update	Provide qualitive /quantitive evidence of benefits of OD interventions.	6 mths time	GD	
14.0	Education Strategy Update	Highlight to Board the difficulties with current education provider for ACP training	December	DW	

Blank page

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Workforce Report – January 2016

Action requested/recommendation

The Board of Directors is asked to read the report and discuss.

Summary

The attached document provides information up to December 2015, relating to key Human Resources indicators including; sickness and recruitment and retention.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☐
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

Outcomes 12, 13 & 14

Progress of report

Risk No risk

Resource implications	There are Human Resources implications identified throughout this report
Owner	Patrick Crowley, Chief Executive
Author	Polly McMeekin, Deputy Director of Workforce
Date of paper	January 2016
Version number	Version 1

Board of Directors – 27 January 2016

Human Resources Report – January 2016

1. Introduction and background

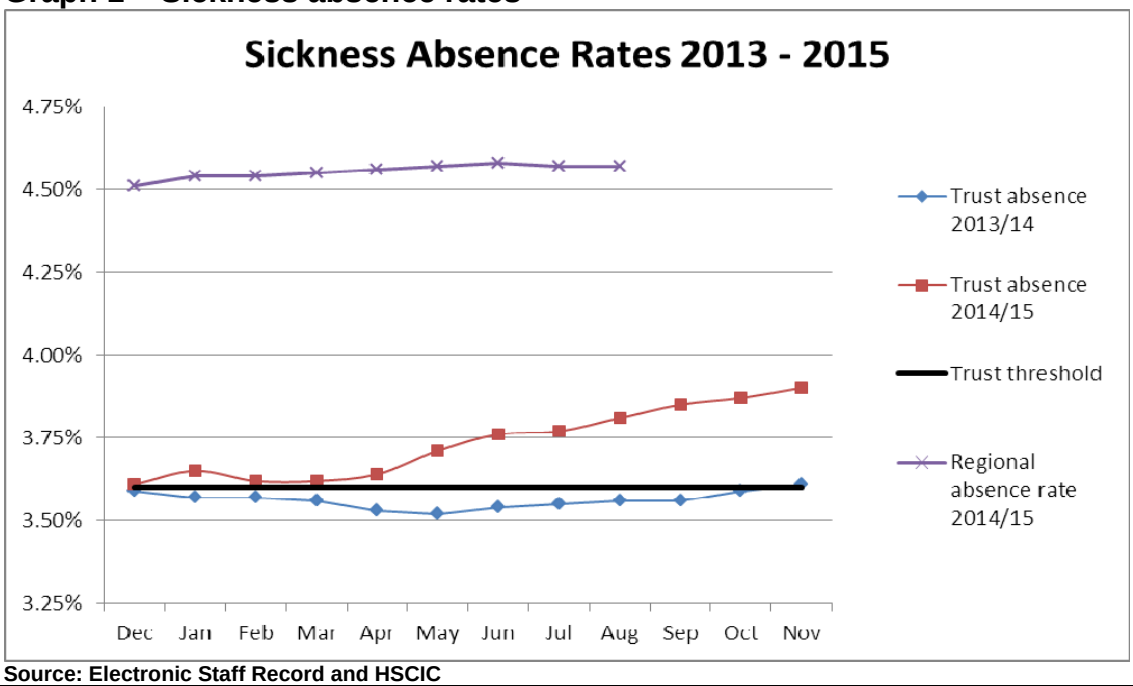
This paper presents key workforce metrics up to December 2015 (where available). The narrative will detail trends and any actions which are being taken to address specific issues. Of particular note:

- A further increase in the annual absence rate to 3.90%, compared to 3.61% at the start of the 12 month rolling period. The monthly absence rate in November was higher than in the same month in the past two years.
- An increase for the sixth month in a row in the annual turnover rate. There have been increases in turnover in most staff groups, although the turnover rate for registered nursing and midwifery staff has reduced in each of the last two months.
- New incentives to make work on the internal nurse bank more attractive are proving successful with an increase in bank fill rates and a significant increase in the number of applications to join the bank.
- The first of three planned periods of industrial action by junior doctors in response to proposed contract changes took place on 12th – 13th January. No inpatient elective procedures were cancelled as a result although 113 outpatient appointments were postponed.
- Greater emphasis is being placed on exploring alternatives to suspension which has resulted in significant reductions in number and duration of suspensions.

2. Human Resources Report

2.1 Sickness Absence

Graph 1 – Sickness absence rates



Source: Electronic Staff Record and HSCIC

The above graph compares the rolling 12 month absence rates to the Trust's locally agreed threshold and to the regional (Yorkshire and Humber) sickness absence rates.

Although the Trust's absence rates continue to be well below the regional absence rates the cumulative annual absence rate has been steadily increasing over the course of the last year from 3.61% in December 2014 to 3.90% in November 2015.

The monthly absence rate in November was 4.37%. Whilst seasonal variations are expected in sickness absence rates, the rate in November 2015 was higher than in the same month of 2014 (3.98%) and 2013 (3.84%).

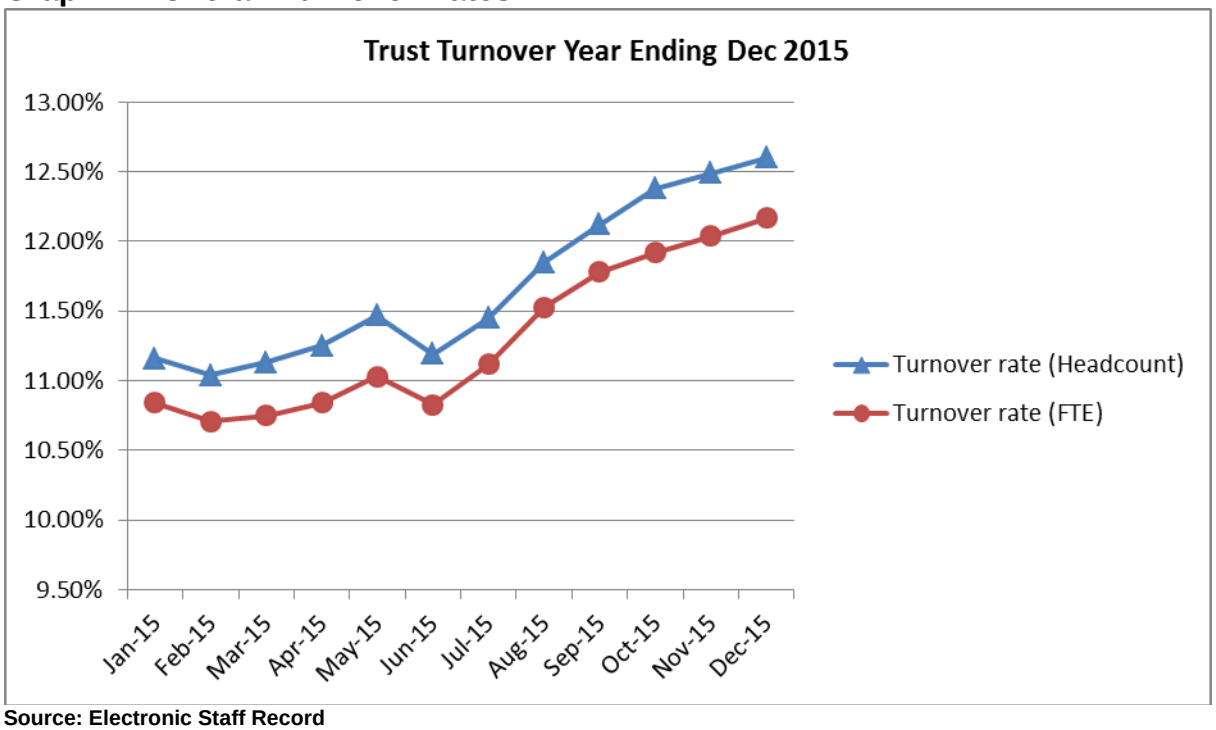
The top three reasons for sickness absence based on both days lost and number of episodes are shown in the table below:

Top three reasons (days lost)	Top three reasons (episodes of absence
Anxiety/stress/depression – 20,225 days lost (19.49% of absence days lost)	Gastrointestinal – 3,084 episodes (18.48% of all absence episodes)
MSK problems, inc. back problems – 18,357 days lost (17.69% of absence days lost)	Cold, cough, flu – 2,910 episodes (17.43% of all absence episodes)
Gastrointestinal – 8,844 days lost (8.52% of absence days lost)	Anxiety/stress/depression – 1,466 episode (8.78% of all absence episodes)

2.2 Turnover

The annual turnover rate increased in December for the sixth consecutive month. Based on full time equivalent leavers the turnover rate for December 2015 was 12.17%; based on headcount the rate was 12.60%.

Graph 2 – Overall Turnover Rates



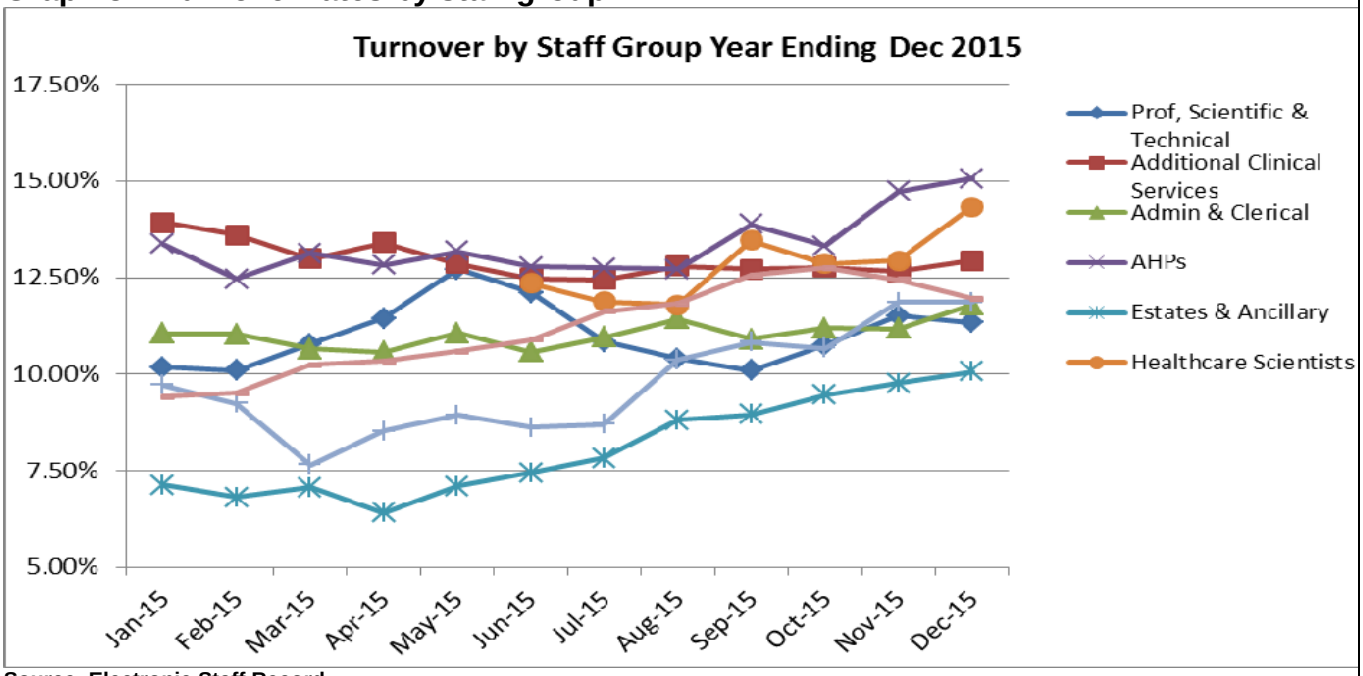
Source: Electronic Staff Record

Turnover amongst six of the eight staff groups has increased this month. The staff groups with the highest annual turnover rates in December 2015 were: Allied Health Professionals

(15.07%), Healthcare Scientists (14.34%) and Additional Clinical Services, this staff group is mostly made up of band 2 – 4 support staff (12.94%).

The rate of turnover amongst registered nursing and midwifery staff has been highlighted in this report previously as being higher than the Trust average and increasing over the course of the last year. The annual turnover rate for this group has reduced in each of the last two months and is now 11.96% which is slightly below the Trust rate; although still much higher than at the start of the year (9.41% in January 2015).

Graph 3 – Turnover rates by staff group



Source: Electronic Staff Record

The turnover rate for Healthcare Scientists is only included from June 2015 onwards. This is due to a re-coding exercise in 2014 relating to information used to record staff in this group which means that annual data is only accurate from June 2015.

Please note that when calculating turnover both junior doctors on rotational contracts and bank staff are excluded to prevent distorting the turnover figure. This is a common approach used across the NHS for calculating turnover.

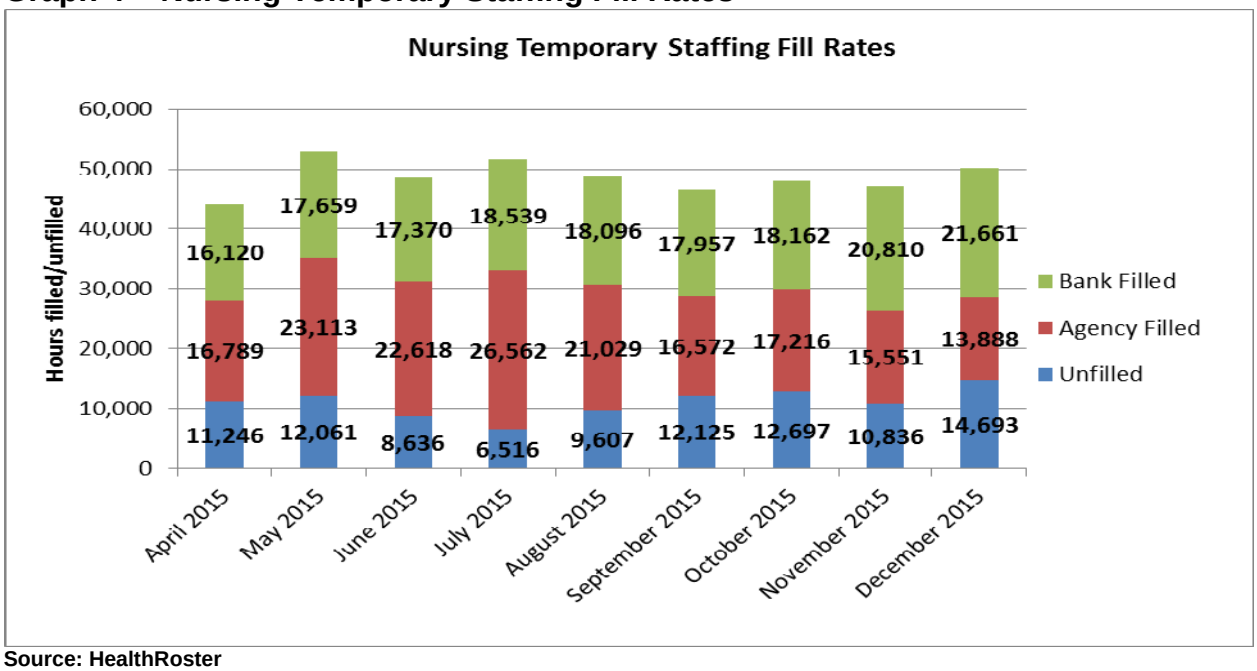
2.3 Temporary workforce

The Trust introduced a number of incentives for bank work in November and December. These include:

an increase in pay rates of 5% above incremental progression for all bank work; the ability for bank only workers to progress to the top of the payscale (rather than being capped at the third point as was previously the case) so that remuneration is reflective of experience; an additional enhancement to pay of 15% for substantive staff who undertake bank work during the winter period and finally weekly pay is also now being offered to both nursing and medical staff undertaking bank work.

The graph below depicts the increase in bank fill rates in November and December 2015 but also an increase in demand in December.

Graph 4 – Nursing Temporary Staffing Fill Rates



Source: HealthRoster

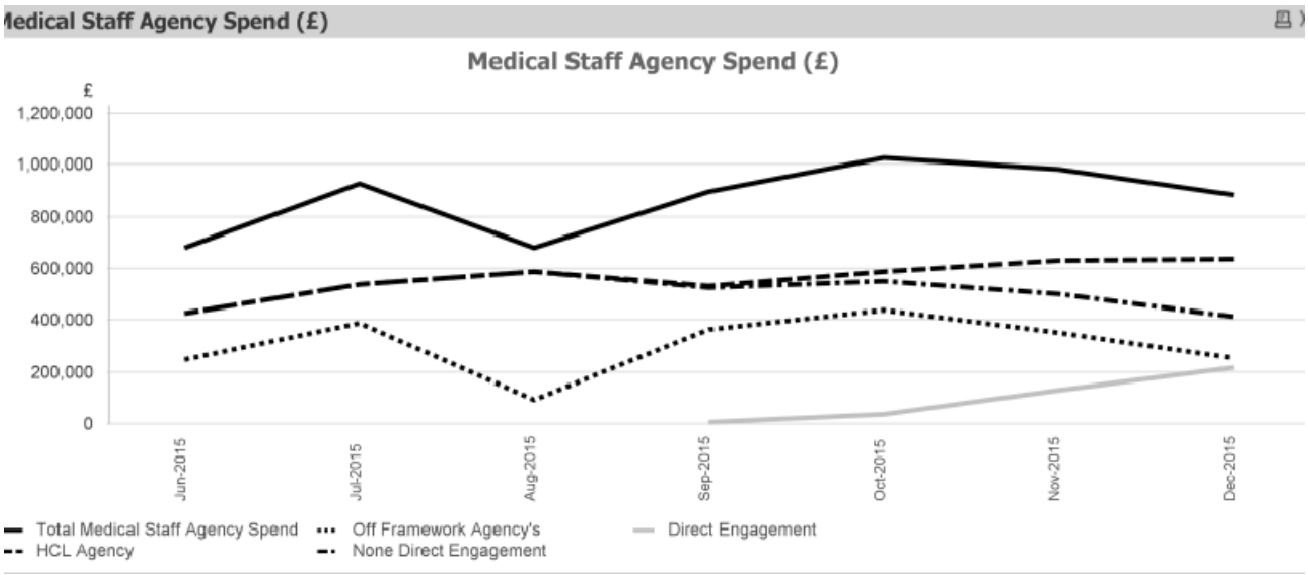
There has been increased interest in joining the bank since the new incentives were introduced with more than 100 applications from substantive staff since 1st November 2015.

During 2015 the Trust introduced a Master Vendor contract and Direct Engagement for the supply of medical temporary staffing. The graph below shows the trends in relation to medical agency spend.

Agency spend for doctors reduced in November and December compared to previous months. Within this reduced rate there has been an increase in expenditure via HCL (our Master Vendor) which comprises both framework agency expenditure and Direct Engagement expenditure. Off framework agency expenditure reduced in November 2015 compared to October.

It is important to note that the graph below is based on invoices paid only.

Graph 5 - Medical Agency Spend



There continues to be a requirement to report on a weekly basis to Monitor all agency usage which is not compliant with the new rules introduced in October and November 2015. These rules relate to use of off framework agencies for the supply of nursing staff and price caps on agency use for all staff groups. Following significant negotiations with agencies and benchmarking with neighbouring Trusts more agencies are reducing their rates in line with the price caps.

There are, however, instances that continue to be reported each week of temporary staffing usage which is not compliant with the rules. All of these instances are subject to scrutiny at a senior level and only those that affect patient safety are approved.

Further reductions in the price caps will come into force on 1st February 2016. We have already started to have discussions with agencies to negotiate these rates down and to advise that we will not be able to make bookings where the rate being offered is not compliant with the cap as set by Monitor.

2.3 Industrial action

The first of three planned periods of industrial action by junior doctors over their contractual negotiations took place on 12th – 13th January 2016. This is in response to proposals around changes to the junior doctor contract. The strike action on 12th January was a 24 hour strike where only emergencies were being covered.

According to national NHS England figures, of the 26,000 junior doctors who were due to work during the 24-hour stoppage 47.4% attended work.

No inpatient elective procedures were cancelled although 113 outpatient appointments were postponed.

Two further strikes are scheduled:

- Tuesday 26 January 8am to Thursday 28th January at 8am (48 hours) - emergency care only;
- Wednesday 10 February 8am to 5pm - full withdrawal of labour.

2.4 Employee Relations Activity

The table below describes the number and type of employee relations activity during in each month since September 2015.

* denotes staff on medical and dental terms and conditions are excluded from the figures as these are reported by the Professional Standards Team (MHPS).

Employee Relations Activity	**September 2015**	**October 2015**	**November 2015**	**December 2015**
Number of Disciplinaries (including investigations)*	18	15	9	12
Number of Grievances	6	7	8	7
Number of Formal Performance Management Cases (Stage 2 and 3)*	3	4	7	8

Number of Employment Tribunal Cases*	5	7	4	5
Number of Active Organisational Changes (including TUPE)	18	12	9	6
Number of long term sick cases ongoing	Not previously reported	142	139	188
Number of short term sick cases (Stage 2 and 3)	Not previously reported	123	136	147

The HR team has recently started to monitor the cost to the organisation of suspensions to understand the impact of changes in approach to how cases are handled. The cost of suspensions in quarter 1 of this financial year was £40,000 compared to £13,000 in quarter 3. Greater emphasis is being placed on exploring alternatives to suspension in order to reduce this further.

2.5 Freedom to Speak Up Guardian

It has recently been announced that the Care Quality Commission has appointed Dame Eileen Sills, the Chief Nurse at Guy's and St Thomas' NHS Foundation Trust, as the first national guardian for NHS whistleblowers.

The "national guardian for the freedom to speak up" was a key recommendation of Sir Robert Francis' review into the treatment of NHS whistleblowers. Dame Eileen will have four key duties: providing support and advice to local whistleblower guardians based in NHS Trusts; supporting the system by sharing good practice and reporting on common themes; advising Trusts and advising staff raising concerns. However, the role is not responsible for investigating individual whistleblowers' concerns, and also lacks statutory powers. The post will be hosted by the Care Quality Commission and the regulator has pledged to protect the role's independence, adding the guardian will have the freedom to criticise the CQC "if they feel it is necessary".

In addition the consultation on the draft national integrated whistleblowing policy also recommended by Sir Robert Francis closed on 8th January. The outcome of the consultation should determine whether NHS Trusts are mandated to adopt the national policy or supported in retaining their local policy should it meet the required standard. The Trust's Raising Concerns and Whistleblowing Policy was revised in February 2015 in line with many of the recommendations from Sir Robert Francis. The Trust announced Mr Philip Ashton, Non-Executive Director and Senior Independent Director as Freedom to Speak Up Guardian in September 2015.

3. Conclusion

This report has detailed key workforce metrics highlighting any issues or trends. In those areas where there are issues, actions which have already been identified have been detailed. The impact of actions will become apparent in subsequent reports.

4. Recommendation

The Board of Directors is asked to read the report and discuss.

Author	**Polly McMeekin, Deputy Director of Workforce**
Owner	**Patrick Crowley, Chief Executive**
Date	**January 2016**

Blank page

Environment & Estates Committee

Attendees: Mike Sweet (MS) (Chair), Jennie Adams (JA), Brian Golding (BG[1]), Dave Biggins (DB), Colin Weatherill (CW), Brian Golding2 (BG[2]), Jane Money (JM), Janet Mason (JMa), Carol Birch (CB), Zara Ridge (ZR), Paul Bishop (PB), Andy Betts (AB)

Apologies: Jacqueline Carter (JC), Fiona Jamieson (FJ),

	Agenda item	AFW /CRR	Paper	Comments	Assurance	Attention to Board
1.	**Welcome / Introductions.**			Introductions were made. BG[1] confirmed JC's apologies for the meeting and advised ZR will take the minutes of today's meeting. BG[1] updated the Committee of the Estates and Facilities structure changes following Andy Fairgrieve's departure, and reassured members that the new structure will offer clarity for the end service users. The structure will be reviewed in 12 months. MS requested a structure chart be cascaded to the Committee. This was noted.		
2.	**Apologies for absence.**			Jacqueline Carter (JC), Fiona Jamieson (FJ),		
3.	**Risk Register** • **Estates Strategy**	DEO1		The Committee noted that at present there was only 1 corporate risk relating to Estates and Facilities. BG explained that the estates & facilities Risk Register contained many different estate related risks and it was agreed that in order to enable the Committee to fulfil its duties these would be prioritised to suit the availability of capital. MS suggested that we review the E&F RR highlighting the top 10 risks at the next meeting. This was agreed.		
4.	**Minutes of last meeting held on 23rd September 2015.** **Matters Arising** • **SWMH interim energy audit report**		√	The minutes of the last meeting were approved as a correct record. As agreed at the last meeting BG[2] provided an initial update to the Committee that identified why Selby Hospital is underperforming against its energy targets. This identified that as the solar panels had not been registered for the feed in-tariff at the outset the opportunity had been missed added to which the night time load was higher than anticipated. BG[2] clarified that the assessment was made on the property as a hospital	BoD Oct '15	

	• **PLACE Results 2015**			and not a shared use building, that the CHP (Combined Heat & Power unit) output is erratic and that the control strategy needs to be re-visited. BG[2] confirmed he was confident he can drive changes and improve the output. This was noted. As anticipated at the last meeting BG[1] confirmed that an awareness day had been held which involved key stakeholders such as Kier to ensure there was a common understanding of PLACE requirements. The PLACE assessment methodology will also be sent to the Capital Team to be included with future schemes. The Committee discussed the type of works that would improve the environment for those suffering from dementia. JA urged that any funding applications for this area of works should be sent to the Charitable Funds Committee as this is one of their priority areas. This was noted. As noted at the last meeting CB advised that feedback sessions were carried out in October where PLACE action plans were discussed with the governors and Healthwatch. CB met with Healthwatch and discussed PLACE training which is currently being planned for approximately 7th March and 10th June 2016. It was noted that the PLACE report was received by the Board.	BoD Sept '15	
5.	**Premises Assurance Model (PAM)** • **YTH PAM compliance report.**		√	DB presented the latest quarterly report and highlighted some improvements since the last report. MS asked if it would be helpful to have all sections included into one chart to enable comparisons to be made. DB explained the format is set by the DoH PAM team and outwith our control. It was noted that in the safety domain, natural gas and building/refurbishment work are highlighted in red (low compliance). JA asked for clarification on what was outstanding. It was explained that this is primarily as a result of incomplete policies and procedures. DB is tasked with identifying shortcomings in policies and procedures and is currently creating a standardised template for procedures and implementing them in the new year. Workshops will be held for Estates & Facilities staff to inform and support them in adopting them. This was noted. DB reported that as part of the patient experience, one area that requires improvement is the switchboard. He confirmed that action has been taken based on the monthly PALS report feedback and the hospital greeting message has been altered for people using the service. The change has resulted in a significant improvement. DB explained that the 2015 report is looking a lot healthier than 2014. It is anticipated that the CQC will use PAM as an auditing tool. MS requested		BG to update

				we use this as a benchmarking tool and that BG[1] present the PAM progress to the Board in March. This was noted. DB explained that he has discussed the report with Internal Audit and agreed an annual audit will take place.		Board
6.	**Health & Safety** • **Terms of Reference for H&S/NCRG.** • **Quarterly report.**		√ √	Following amendments agreed at the previous Committee meeting, the final version of the ToR for the Health, Safety & NCRG were approved. CW presented the latest quarterly Health, Safety & Security report and provided an update to the Committee particularly around our monitoring systems. This included the average number of incidents per month and an exception report. It was noted that Estates & Facilities incidents account for approximately 1% of the Trust's overall reported incidents. CW explained that he is cascading the process and providing training on the DATIX system to ensure accuracy of allocation. JA highlighted the reduction of reported serious injuries which should be noted. CW informed that the HSE have changed the RIDDOR reporting process guidelines under which we are expected to see a reduction. MS queried if we could provide further detailed analysis on slips, trips and falls in addition to separating the clinical from the environmental incidents reported. CW agreed to consider how this could be best presented. MS also asked if a trend analysis could be provided. CW agreed to investigate this for the next report. This was noted.		
7.	**Sustainable Development** • **Sustainable Development Management Plan (SDMP) – Action Plans and Baseline Carbon footprint data.**		√	JM presented the draft Annual Sustainable Development Report. She explained that within the report the Trust's sustainable development progress is measured against the Good Corporate Citizenship model. The report shows some areas as good and others such as "adaptation" and "models of care" have not been progressed at the present time. BG[1] explained that these 2 areas require joint working with other organisations such as NHS England and the CCGs. JM explained that she has reviewed the Sustainable Development Management Plan (SDMP) and in agreement with work stream leads, adjusted the action plans to reflect the current priorities. The revised SDMP is attached to the annual report. After discussion it was agreed that the following changes would be made to the draft report prior to it going to BoD: • A summary of the key actions will be lifted from the SDMP action plan and brought to the front of the report for ease of reference.		Annual Report to BoD. BG to lead.

	• **Carbon Energy Fund Project – Scarborough and Bridlington**			12 key actions can now be found in the BoD cover sheet and in section 8 of the Annual Report. • National averages for acute providers will be included where available in the Good Corporate Citizen assessments to enable comparisons against Trust progress. This is now included in page 8 of the Annual Report and in Appendix 6 of the SDMP. Subject to these changes it was agreed that the Annual Report would proceed to the Board of Directors. The Committee considered the baseline carbon emission data that is contained in Appendix 4 of the SDMP. It was noted that although the Business Case pro forma includes a section on carbon emissions a change in culture is required to ensure that Business Case authors are considering the impact of carbon emissions when preparing BCs. MS suggested this Committee review BCs which contain significant CO_2 emission implications. JM advised that she is already discussing this with Finance. This was noted. JA noted that the procurement element of the Trust's carbon footprint as identified in the pie chart on page 11 of the Annual Report is the most significant factor. BG^2 advised that to reduce this the Trust will have to work with suppliers to drive down their Carbon Emissions and demonstrate benefits. It is not yet clear how this might be achieved. It was noted that the Trust's Carbon footprint per patient contact is showing a consistent reduction as shown in page 64 of the SDMP. BG^2 presented a report to the Committee on progress with the Carbon Energy Fund (CEF) project at Scarborough and Bridlington. The project is in progress and 95% complete and will be finished by January. MS noted that the Scarborough project will have a higher return than York. However, BG^2 explained that more of the savings were being invested in new plant and equipment across the Scarborough site to increase site resilience. This was noted.		
8.	**Travel & Transport Group** • **ToR for T&T Group**		√	BG^1 explained the work of the Travel &Transport Group and the Committee considered the ToR that had been provided. These were approved subject to: MS will not be a group member going forward but will attend on an ad hoc basis. This was noted. At this point in the meeting it was noted that minutes from reporting groups would be brought to the meeting but would highlight (item by item) those matters that they wished to draw to the attention of the E&E Committee.		

9.	**Space Management Group**			Deferred until next meeting.		
10.	**NHS Protect** • **2015 NHS Protect security review submission.**		√	JM explained that the Trust is obliged to carry out an annual self-assessment of security standards as defined by NHS Protect. She presented an updated 2015 action plan as discussed at the last Committee meeting. This was noted.		
11.	**Any Other Business**			The Committee asked for an update on the CQC Action Plan related to E&F. It was noted that there was only 1 action, which was to improve security of health records in the school nurse building on the Bootham Hospital site. PB reported that this was complete. Post meeting note: below is the requirement together with the Trust's response. Requirement The provider must ensure that patient records are fully secured when stored, specifically within the school nursing records. Regulation 17 (2)(c) HSCA (Regulated Activities) Regulations 2014 Good governance Action Action has been taken to undertake a new risk assessment of the building containing school nursing records. As a result some minor adjustments have been made to this facility that provide additional security		
12.	**Future meeting dates.**			Thursday 17th March 2016 @ 10am. Venue - Bridlington Hospital.		

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Sustainable Development Report

Action requested/recommendation

It is recommended that the Board of Directors:

- Continue to recognise the importance of Sustainability to the success of the organisation.
- Review and endorse their support for the updated Sustainable Development Management Plan (SDMP)..
- Review the original adopted carbon reduction targets agreed in the 2009 Sustainable Development - Board Statement. Adopt the new NHS Carbon Reduction Plan as an integral part of the action being addressed by the Sustainable Development and replace the 2020 target of 26% with the revised recommendation of 34%.
- Give appropriate consideration to carbon weighted investment impact assessments as an integral part of Business Case approval.
- Support the Sustainable Development Group in adopting climate change as concomitant risk in the corporate risk register.

Summary

Over the last twelve months, the Trust has progressed the objectives set out in the Sustainable Development - Board Statement. A brief description of progress is provided below:

- **Compliance with Legislation:** The Trust compliance with legislation is a fundamental element of the NHS Premises Assurance Model (NHS PAM). NHS PAM provides a robust management delivery, monitoring and validation demonstrating Trust compliance. PAM progress is updated and reported regularly to the Board.
- **Good Corporate Assessment Model:** The Sustainable Development Group has completed the annual Good Corporate Citizenship (GCC) on line assessment. In November 2014, the Trust achieved an attainment score of 24%. In December 2015, the Trust achieved an attainment score of 33%. However, if the most recently added domain areas where little progress has been made are removed, the score would have been 43%, against a target of 50% It should also be noted that in 2014/15 only 19% of NHS organisations used the GCC Assessment Model and these scored an average of 43% over the 9 sections. The NHS Sustainable Development Unit are in the process of updating the comparison data to consider those submitting since April 2015.

- **Carbon Emissions:** The total measured Trust emissions for the base year of 2007/2008 are assessed to 74,751 tonnes CO2e. The total measured Trust emissions for the base year of 2014/2015 are assessed to 109,726tonnes CO2e. This represent of an increase of plus 47% against a target reduction of minus 10%. However, it should be noted that the number of patients have continued to rise since the baseline year and that the carbon savings per patient contacts have declined year on year giving an overall decrease of 29%. The total emissions however had a general trend which increased year on year until 2013/14 and in 2013/14 a reduction in emissions was achieved. Notable decreases have also been measured in relation to carbon emissions from energy within the last year which has achieved a 7 % reduction against the 2013/14 levels. These emissions will reduce further in 2016 as the completion of the Scarborough and Bridlington Carbon Energy Fund Projects which will realise further savings of a 15% reduction against 2014/15 Trust carbon energy savings).
- **Baseline Emissions:** The Sustainable Development Management Plan now includes baseline carbon emissions for all Trust activities from 2007/08 to 2014/15. The baseline emissions include all migrated properties in the current property portfolio, including Scarborough Trust and the more recent North Yorkshire and York Primary Care Trust properties which were added in 2013/14.
- **Carbon/Sustainability Weighted Investment:** All Business Case submissions now include a specific section detailing the carbon impact and sustainability impact of the requested investment.
- **Concomitant Risk Assessment:** Currently under review within the Sustainable Development Group.
- **Environmental Impact/Continuous Improvement:** Currently under review within the Sustainable Development Group.
- **Integrate Sustainability:** Currently under review within the Sustainable Development Group and this is to be delivered through the actions within section 7 of the SDMP.

Future Actions:

- **Compliance with Legislation:** Continue to adopt and develop the Premises Assurance Model (PAM).
- **Good Corporate Citizen Assessment Model:** Adopt and progress an overall target of 60% compliance by November 2016. Adopt and progress a target of 75% compliance by November 2020.
- **Carbon Emissions:** Procurement- On-going work with suppliers to provide better quality data and promote carbon reduction strategies. Transport: On-going work within the Transport and Travel group and associated Transport and Travel Policy development. CEF capital project at Scarborough and Bridlington to be completed this financial year delivering a predicted annual reduction of 3,000 tonnes CO2e.
- **Baseline Emissions:** Improve the quality of collection methods and data quality to better reflect Trust baseline emissions. Continue to monitor and report baseline emissions annually within the Sustainable

Development Management Plan.

- **Carbon/Sustainability Weighted Investment:** Provide climate change impact assessment support in completing Business Case preparation.
- **Concomitant Risk Assessment:** Develop a Sustainability and Climate Change risk matrix for inclusion within the Trust Risk Register and develop complimentary strategies to mitigate the identified risks.
- **Integrate Sustainability:** Current nominated leads to allocate and identify support resources to progress the agreed strategy and promote wider achievement and attainment. Training programs to be developed and delivered to nominated leads and support resources. This work will be delivered through the actions within section 7 of the Sustainable Development Management Plan (SDMP).

The priority actions from the SDMP for 2016/17, to enable to the Trust to continue to reduce carbon emissions, and help to achieve a 60% Good Corporate Citizen score in 2016, are as follows:

1. Develop a **Sustainable Development Communication and Engagement Plan** to help to integrate the principles of sustainability into all areas of Trust business.
2. Improve **engagement with partners on sustainable development** work by seeking Sustainable Development leads with partner organisations e.g. through Board to Board Meetings.
3. Develop a set of **sustainable procurement objectives with success measured by metrics** including how procurement decisions reduce energy and water use and reduce waste
4. Investigate the possibility of strengthening the **mandatory section on Sustainability in Board template papers** so that the impact sustainability and how the Trust could reduce carbon emissions (through reducing energy from fossil fuels, reducing travel, reducing waste and reducing water use) and adapting to climate change are considered as part of any decision making process.
5. Completion of the **Carbon Energy Fund Project at Scarborough and Bridlington** Hospitals realising a further carbon emissions saving of 3,000 tonnes CO2e
6. Develop a sustainable building strategy as part of **revised capital project procedures** incorporating a capital project procedure that clearly sets out the objectives to achieve BREEAM “Excellent”/ “Very Good”, including the need to gain “innovation credits” in the field of sustainable performance by incorporating innovative technology where practicably feasible and economically viable to do so. **Regular reporting on building sustainably to be introduced to the Capital Programme Executive Group.**
7. Develop a **Trust wide travel plan** –incorporating site specific plans for all main sites. The plan will incorporate actions to reduce carbon emissions through modal shift and procurement and the promotion of healthy and sustainable travel options.
8. Update and complete the **Waste Management Plan** which aims to prevent, reduce and recycle waste, in order to reduce the waste being

sent to landfill.

9. Seek to ensure that sustainability and achieving **sustainable models of care** become part of the clinical care lead responsibility including reducing carbon emissions of service delivery (and or other sustainability metric)
10. Encourage completion /**review of business continuity plans** which require consideration of the consequences arising from current disruptive weather events and raise awareness of longer term trends
11. Investigate the possibility of incorporating Sustainable Development objectives into the staff and Board **induction process and through mandatory training and Leadership Programme** for continuing staff and Board learning & development
12. Develop Sustainability information on the website and via other means which encourages the **public and staff to offer ideas** on how to improve our environment and sustainability

Section 7 of the SDMP provides more details on the current position and the full list of key actions

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☒

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Sustainable Development Group Environment and Estates Committee
Risk	Risk implication detailed in the report
Resource implications	Resources implication detailed in the report
Owner	Brian Golding, Director of Estates & Facilities
Author	Jane Money, Sustainability Manager
Date of paper	January 2016
Version number	Version 1

Board of Directors – 27 January 2016

Sustainable Development Report

1. Introduction and background

The Trust's ultimate objective is "***To be trusted to deliver safe, effective and sustainable healthcare within our communities***", and so the commitment to the Sustainable Development Management Plan, is key to achieving this objective.

"Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs".
(Brundtland report 1992 for first United Nations Conference on Environment and Development)

Sustainable development underpins and runs through the Trust's values.

In 2009 the Board of Directors agreed to establish a Sustainable Development Group, and in 2012 the Board agreed to widen that group to include the enlarged organisation, and to assess our position against the Good Corporate Citizen Assessment tool.

In 2015 the Board received an update on progress since 2012 and adopted a Sustainable Development Management Plan, in line with NHS guidance.

This report provides the Board with an update on progress since 2015, suggests targets to focus resources during 2016/17 and proposes the adoption of the revised Sustainable Development Management Plan, in line with NHS guidance.

2. Compliance with Legislation

The NHS Premises Assurance Model (NHS PAM) brings together a system to gain assurance on:

- Compliance with quality and safety standards
- Efficiency, effectiveness and governance

The York NHS Teaching Hospital foundation Trust introduced NHS PAM in October 2014 using the Department of Health methodology. The model covers a range of Estates and Facilities functions or domains including Sustainability and provides a vehicle for demonstrating compliance with the relevant legislation.

The Trust's NHS Premises Assurance Model Compliance Report was received by the Environment and Estates Committee in September 2015 who recommended that a full assessment would be undertaken in February 2016.

3. Good Corporate Citizenship Assessment

In 2012 the Board agreed to adopt the Good Corporate Citizen Self Assessment tool for the enlarged organisation, (as recommended by the NHS Sustainable Development Unit (SDU)), as a means of gauging progress in the workstreams associated with this agenda.

In 2015 the Board set the target for the Sustainable Development Group of achieving a 50% score for each of the Good Corporate Citizenship domains during 2015 (as recommended by the NHS Sustainable Development Unit).

The assessment tool prompts responses to a range of questions, from which an overall rating is developed. Within nine domains the organisation ranks itself from 'getting started', 'getting there' or 'excellent'.

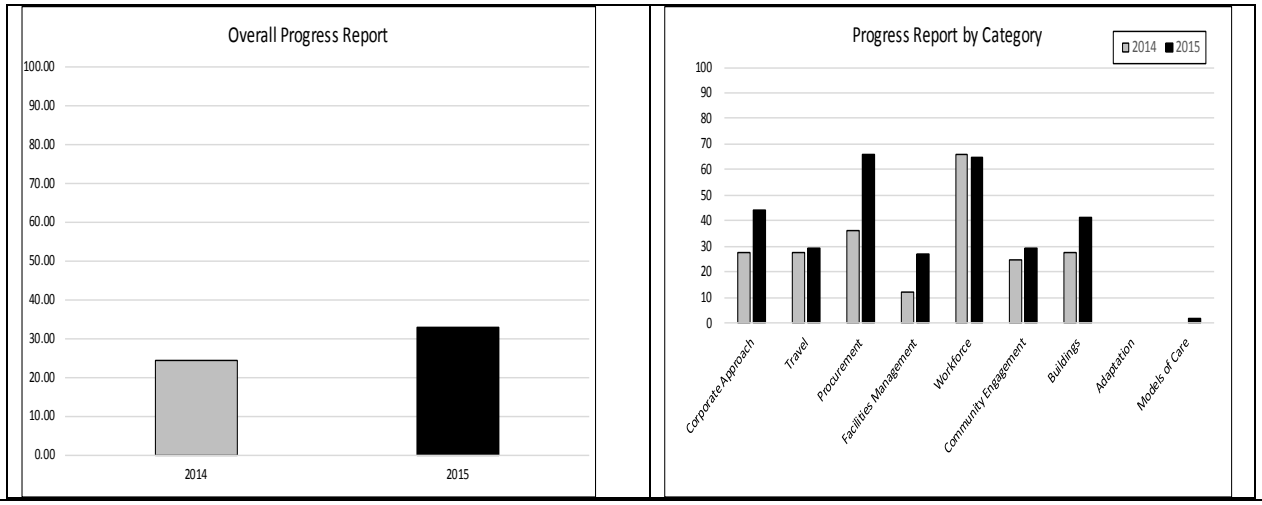
There are 54 statements of intent against which progress is assessed for each of the domains, apart from Corporate Approach which has 9. The domains are as follows:

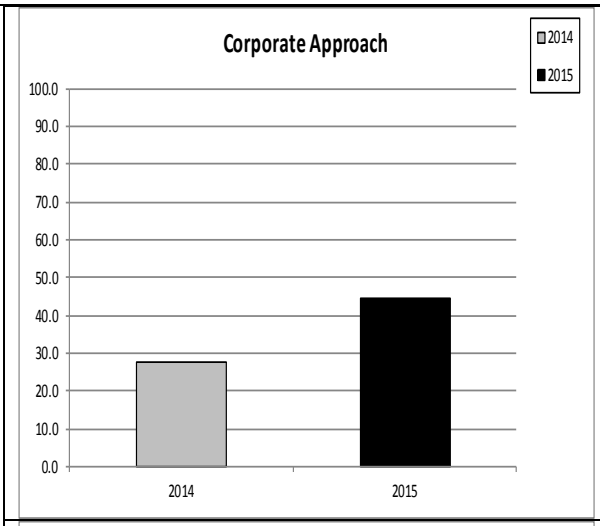
- Corporate Approach
- Travel
- Procurement
- Facilities Management
- Workforce
- Community Engagement
- Buildings
- Adaptation
- Models of Care

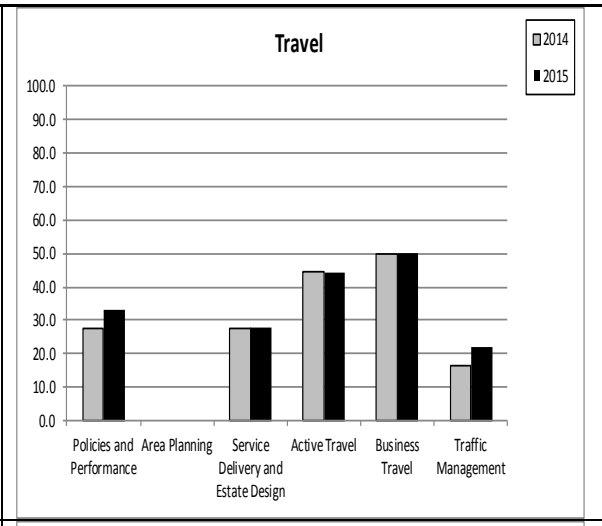
The Sustainable Development Group had assigned work stream leads for each of the domains, and they in turn have, in consultation with others where necessary, completed the assessment.

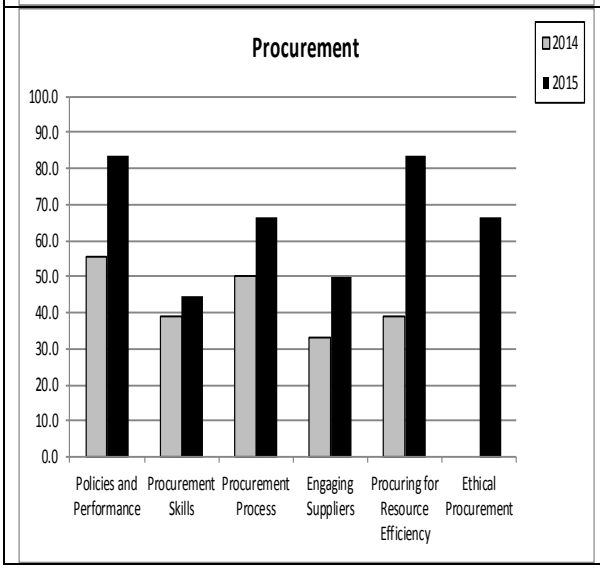
The completed assessments have been uploaded into a national database, held by the NHS SDU, which then allows the Trust access to others' data in order to benchmark.

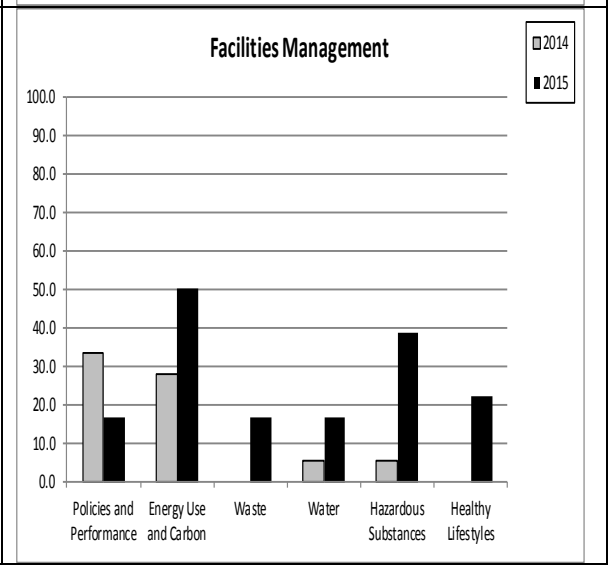
Good Corporate Citizenship Assessment –

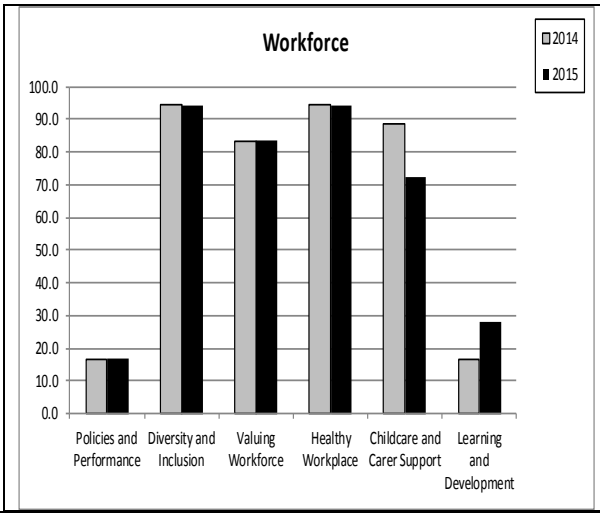


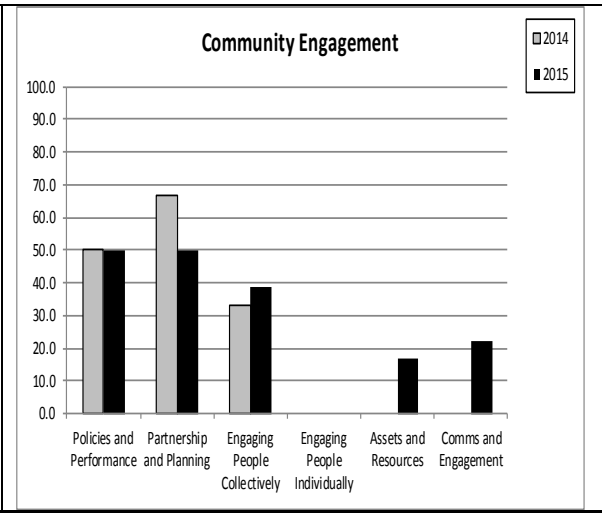

Corporate Approach
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
2014
2015

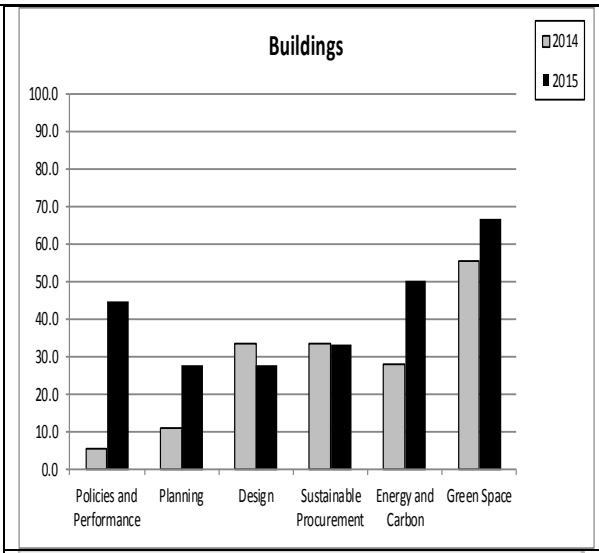

Travel
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Area Planning
Service Delivery and Estate Design
Active Travel
Business Travel
Traffic Management

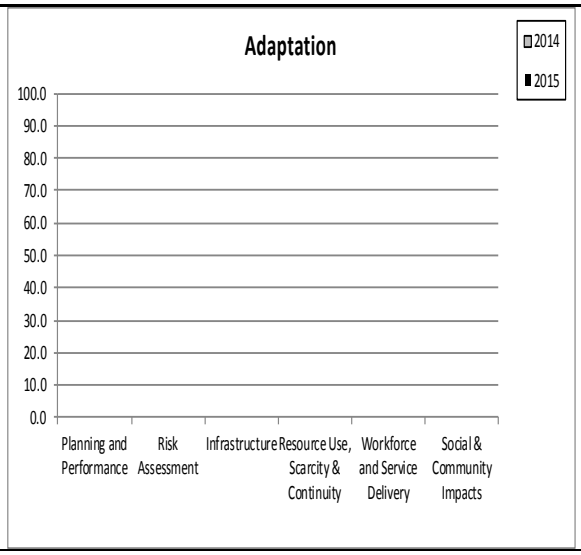

Procurement
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Procurement Skills
Procurement Process
Engaging Suppliers
Procuring for Resource Efficiency
Ethical Procurement

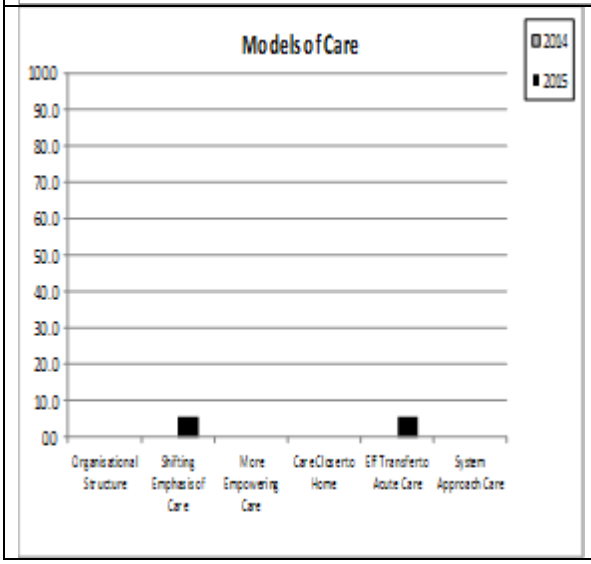

Facilities Management
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Energy Use and Carbon
Waste
Water
Hazardous Substances
Healthy Lifestyles


Workforce
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Diversity and Inclusion
Valuing Workforce
Healthy Workplace
Childcare and Carer Support
Learning and Development


Community Engagement
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Partnership and Planning
Engaging People Collectively
Engaging People Individually
Assets and Resources
Comms and Engagement







The GCC assessment provides the Sustainable Development Group with the opportunity to identify where to target resources, and helps to identify targets for improvement.

As might be expected progress has been better in some domains than others, Workforce, for example, scores well. Also as each section has been completed and scored by the nominated domain lead, there is significant variation in both the interpretation of what constitutes a completed action and the evidence covering progress reported over the last year and the commitment to future actions. There are also likely to be significant differences between the scoring methods of different organisations as the scheme offers significant scope for local interpretation. Independent auditing is not a mandatory requirement of the benchmarking exercise.

The overall score that had been achieved in 2014 was 24%. The 2015 score achieved is now 33% and, whilst some areas have exceeded the target, two areas, models of care and adaptation which were new at the last assessment have made little progress due to staff changes and the absence of a domain lead . Only two areas have exceeded the target, procurement and workforce where some Trust–wide processes are in place and help achieve overall performance scores of 65% in both areas.

Section 7 of the SDMP provides information on each domain area setting out the current position and the key actions proposed for 2016/17.

The NHS SDU suggested that Trusts should aim for a 50% score across all domains during 2015 and 75% by 2020 and so it is proposed that we set an overall target of achieving 60% by this time next year , and ask the Sustainable Development Group to prepare action plans and monitor progress, reporting back to the Environment and Estates Committee quarterly with a six monthly report to the Board.

4. Reduction in Carbon Emissions from the Baseline

The Sustainable Development Management Plan now includes baseline carbon emissions for all Trust activities from 2007/08 to 2014/15 and includes all migrated properties in the current property portfolio, including Scarborough Trust and the more recent North Yorkshire and York Primary Care Trust properties.

The most robust data is that gathered for the last two years whereas some of the earlier data is modelled from existing data. The table below shows the carbon emissions percentage changes from the baseline year of 2007/8 and also the annual change between the last two years as a total and also sub-divided according to the Treasury carbon emissions reporting protocol where scope 1 emissions are the direct emissions from the Trust buildings, and owned vehicles including using fossil fuels e.g. gas, oil and petrol, plus anaesthetic gases. Scope 2 are indirect emissions from electricity and scope 3 are the indirect emissions from the production, delivery and use of goods and services including those from the Trusts procurement / investment , travel from transport not owned by the Trust e.g. train, bus , pool cars, taxi's etc, plus the production, delivery and use of energy and water and the carbon emissions associated with waste collection and disposal services

Scope (tonnes C02e)	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	% Change from 2007/ 08	% Char from 2013/
Scope 1&2 Energy	18,390	18,675	19,320	19,070	19,916	21,283	21,078	19,572	+6.4%	-7.1%
-Total Scope 1&2	21,742	21,924	22,719	22,476	23,735	25,660	25,088	23,954	+10.2%	-4.5%
Total Scope 3	53,009	57,042	61,802	66,456	68,231	72,400	88,999	85,772	+61.8%	-3.6%
Total Scope 1,2 & 3	74,751	78,966	84,522	88,932	91,966	98,060	114,088	109,726	+46.8	-3.8%

The Trust's 2009 approved targets were to achieve NHS *carbon emission targets of 10% by 2015* (the national NHS strategy said that this was from 2007 baseline)*, 26% by 2020 and 80% by 2050.*

These targets have since been revised in national NHS guidance to

- 34% by 2020 from a 1990 baseline (which is stated to be equivalent for Health and Social Care England to 28% from a 2013 baseline)

- 50% by 2025
- 64% by 2030
- 80% by 2050

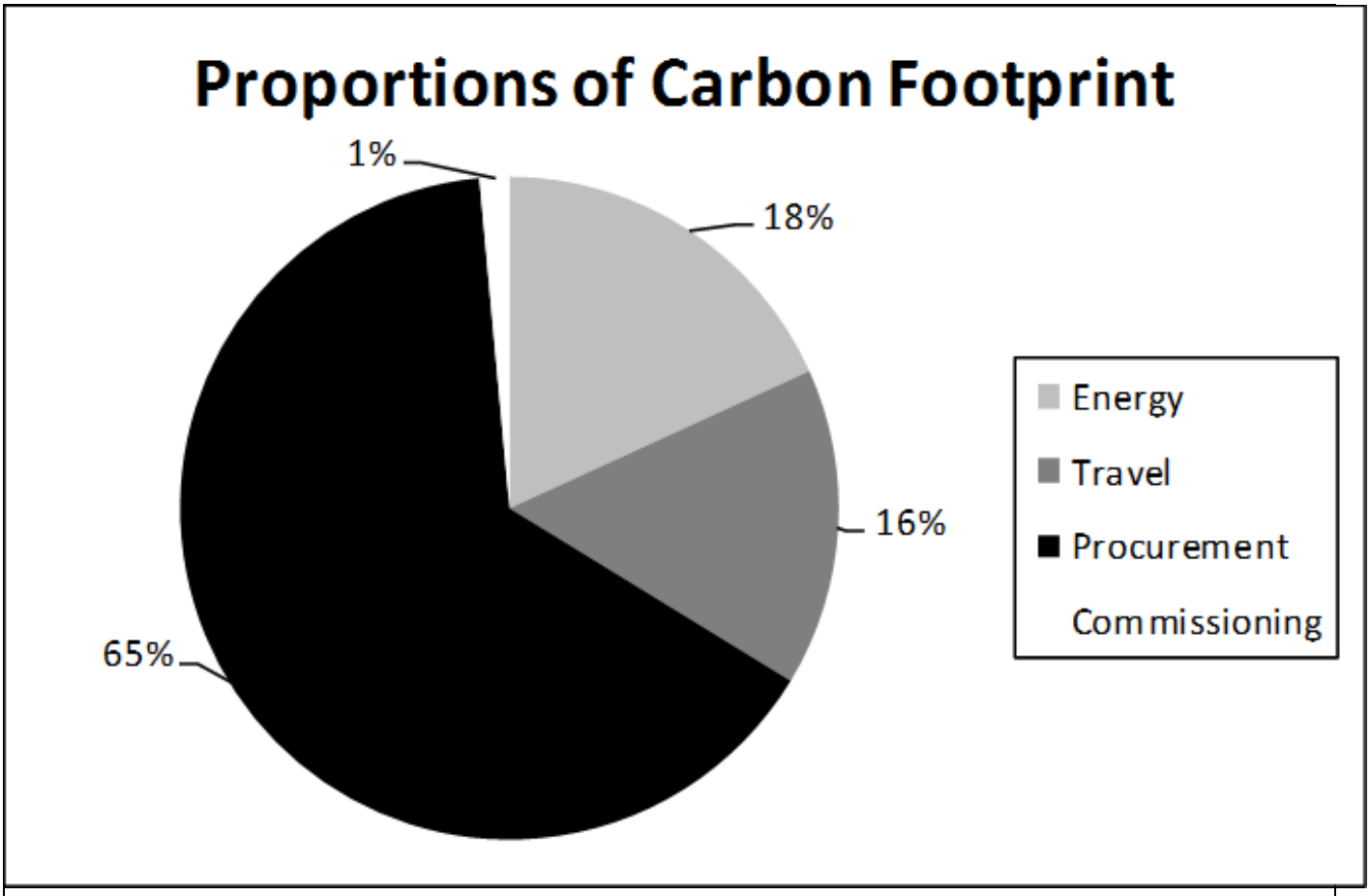
It is clear that these targets have not been met but in the last year some progress has been made in reducing emissions against the previous year's emissions.

The total measured Trust emissions for the base year of 2007/2008 are assessed to 74,751tonnes CO2e. The total measured Trust emissions for the base year of 2014/2015 are assessed to 109,726 tonnes CO2e. This represent of an increase of plus 47% against a target reduction of minus 10%.

However, it should be noted that the number of patients have continued to rise since the baseline year and that the carbon savings per patient contacts have declined year on year giving an overall decrease of 29%. The total emissions however had a general trend which increased year on year until 2013/14 and, in 2013/14, a reduction in emissions was achieved.

Notable decreases have also been measured in relation to carbon emissions from energy within the last year which has achieved a 7 % reduction against the 2013/14 levels. These emissions will reduce further in 2016 as the completion of the Scarborough and Bridlington Carbon Energy Fund Projects which will realise further savings of a 15% reduction against 2014/15 Trust carbon energy savings) or will result in savings of at least 10% on energy emission from the baseline year . By comparison, information from the NHS Sustainable Development Unit has noted that there has been a 4.3% decrease in building energy carbon footprint across NHS Providers in England since the 2007/08 baseline with only a 1.4% reduction in the last year.

The pie chart below demonstrates that the percentage of carbon emissions from procurement have the greatest impact on the Trusts carbon footprint contributing 65 % and therefore the above carbon emission target will only be achieved if procurement carbon emissions are reduced.



5. Carbon Weighted Investment/Procurement

All Business Case submissions now include a specific section detailing the carbon impact and sustainability impact of the requested investment, but currently this is not often challenged unless the project is brought to the attention of the Sustainable Development Group lead, therefore this report asks that the Board give appropriate consideration to carbon weighted investment impact assessments as an integral part of Business Case approval.

Further work will be developed through the various domain leads to reduce carbon emissions in all areas of service delivery and support will be available for those requesting this when preparing the Sustainability Business Case assessment.

6. Inclusion of Climate Change and the Concomitant Risk in the Corporate Register

A request has been made for inclusion of Climate Change in the risk register, but further consideration needs to be given to how a Sustainability and Climate Change risk matrix can be completed for inclusion within the Corporate Risk Register together with the development of complimentary strategies to mitigate the identified risks.

7. Integration of the Principles of Sustainability into all Areas of Trust Business

This requirement will be delivered through the Sustainable Development Management Plan (SDMP) actions. Current nominated leads will meet to allocate and identify support resources

to progress the agreed strategy and promote wider achievement and attainment. Training programs will be developed where required and delivered to nominated leads with support resources.

The top twelve priority actions from the SDMP for 2016/17 to enable to the Trust to continue to reduce carbon emissions, and help to achieve a 60% Good Corporate Citizen score in 2016 are as follows:

1. Develop a **Sustainable Development Communication and Engagement Plan** to help to integrate the principles of sustainability into all areas of Trust business.
2. Improve **engagement with partners on sustainable development** work by seeking Sustainable Development leads with partner organisations e.g. through Board to Board Meetings
3. Develop a set of **sustainable procurement objectives with success measured by metrics** including how procurement decisions reduce energy and water use and reduce waste
4. Investigate the possibility of strengthening the **mandatory section on Sustainability in Board template papers** so that the impact sustainability and how the Trust could reduce carbon emissions (through reducing energy from fossil fuels, reducing travel, reducing waste and reducing water use) and adapting to climate change are considered as part of any decision making process.
5. Completion of the **Carbon Energy Fund Project at Scarborough and Bridlington** Hospitals realising a further carbon emissions saving of 3,000 tonnes CO2e
6. Develop a sustainable building strategy as part of **revised capital project procedures** incorporating a capital project procedure that clearly sets out the objectives to achieve BREEAM “Excellent”/ “Very Good”, including the need to gain “innovation credits” in the field of sustainable performance by incorporating innovative technology where practicably feasible and economically viable to do so. **Regular reporting on building sustainably to be introduced to the Capital Programme Executive Group**
7. Develop a **Trust wide travel plan** –incorporating site specific plans for all main sites. The plan will incorporate actions to reduce carbon emissions through modal shift and procurement and the promotion of healthy and sustainable travel options.
8. Update and complete the **Waste Management Plan** which aims to prevent, reduce and recycle waste and so reduce waste to landfill.
9. Seek to ensure that sustainability and achieving **sustainable models of care** become part of the clinical care lead responsibility including reducing carbon emissions of service delivery (and or other sustainability metric)
10. Encourage completion /**review of business continuity plans** which require consideration of the consequences arising from current disruptive weather events and raise awareness of longer term trends
11. Investigate the possibility of incorporating Sustainable Development objectives into the staff and Board **induction process and through mandatory training and Leadership Programme** for continuing staff and Board learning & development
12. Develop Sustainability information on the website and via other means which encourages the **public and staff to offer ideas** on how to improve our environment and sustainability

Section 7 of the SDMP provides more details on the current position and the full list of key actions.

8. Conclusion

The Sustainable Development Group is making good progress in several areas of sustainable development and has completed a second Good Corporate Citizenship Assessment, which highlights areas where further work is required to develop the SD Management Plan .

The Sustainable Development Management Plan has been revised, to consolidate the progress and the work plan to assist with achievement of objectives and targets.

9. Recommendation

It is recommended that the Board of Directors:

- Continue to recognise the importance of Sustainability to the success of the organisation.
- Review and endorse their support for the updated Sustainable Development Management Plan.
- Review the original adopted carbon reduction targets agreed in the 2009 Sustainable Development - Board Statement. Adopt the new NHS Carbon Reduction Plan as an integral part of the action being addressed by the Sustainable Development and replace the 2020 target of 26% with the revised recommendation of 34%.
- Give appropriate consideration to carbon weighted investment impact assessments as an integral part of Business Case approval.
- Support the Sustainable Development Group in adopting climate change as concomitant risk in the corporate risk register.

10. References and further reading

NHS Sustainable Development Unit - www.sduhealth.org.uk

Author	**Jane Money Sustainability Manager**
Owner	**Brian Golding, Director of Estates & Facilities**
Date	**January 2016**

York Teaching Hospital NHS
NHS Foundation Trust

Sustainable Development Management Plan

2016 – 2020

Chairman/ Chief Executive

We very much welcome this updated Sustainable Development Management Plan, and encourage you to read it and let us have feedback as a means of making all of the services provided by the Trust more sustainable and environmentally friendly, making the organisation a great place to work or visit.

Our Trust Values are underpinned by this agenda, in particular in the development and enabling of strong partnerships with other organisations and the broader community and the improvement of our facilities and protection of the environment.

With 9 in-patient sites and a staff of 8,700 we recognise that our actions can have a significant effect on both the environment and the communities that we serve. If we are able to raise awareness amongst all of our staff and patients, and this is shared with their families and friends, then we truly will be able to make a difference.

We are committed to demonstrating leadership in sustainability, so that our services are fit for today's needs without compromising the ability of those that follow us to meet theirs. This plan sets out ambitious targets, and we look forward to reporting on our achievements over the coming years.

Patrick Crowley – Chief Executive

January 2016

Contents

Executive Summary

Sustainability is the principle of strategically ensuring the long term resilience of the health system by establishing a quality and efficient service that is capable of using resources today that does not prejudice our ability to deliver health care tomorrow.

The Trust commitment in 2009 to Sustainable Development is as relevant today as it was then and is being addressed through the further commitments to the NHS Carbon Reduction Strategy and to the Good Corporate Citizenship Assessment Model, with the recent additional commitment to tackling adaptation to climate change. Section 2 details each of the commitments and the sections which follow set out the progress and prioritise actions for 2016/17.

Whilst it is recognised that some of the 2009 commitments are still work in progress it is clear that much has already been achieved since the original commitment. The Sustainable Development Group meets quarterly to progress the work set out in the Sustainable Development Management Plan tackling the environmental, social and economic aspects of coordinating the integration of sustainability into all areas of Trust business.

Progress against this plan will be reviewed regularly to ensure that the Trust continues to stays focussed on integrating sustainability principles and practices throughout the organisation, reducing carbon emissions, and using the 60% GCC score in 2016 as a focus for action planning and the aim of achieving a score of at least 75% by 2020.

Whilst carbon emissions from energy are now reducing as a result of the Carbon Energy Fund programme at York, Scarborough and Bridlington, work must accelerate in relation to procurement as the growth in carbon emissions for the category has increased by 62% since the baseline year and is currently approximately 65% of the Trusts current carbon footprint. It is recognised that investment decisions must take account of and mitigate against rising carbon emissions.

1. Introduction to Sustainable Development

Use of the adjective sustainable and the noun sustainability are now quoted on a daily basis to support numerous arguments and causes without ever really defining the context of their use.

But sustainability is not a new concept.

In 1983, the United Nations expressed their concerns around the accelerating deterioration of the human environment and natural resources and the consequences of deterioration for economic and social development.

Under resolution 42/187, the United Nations General Assembly set up their World Commission on Environment and Development chaired by the former Norwegian Prime Minister Dr Go Harlem Brundtland, now referred to as the Brundtland Report.

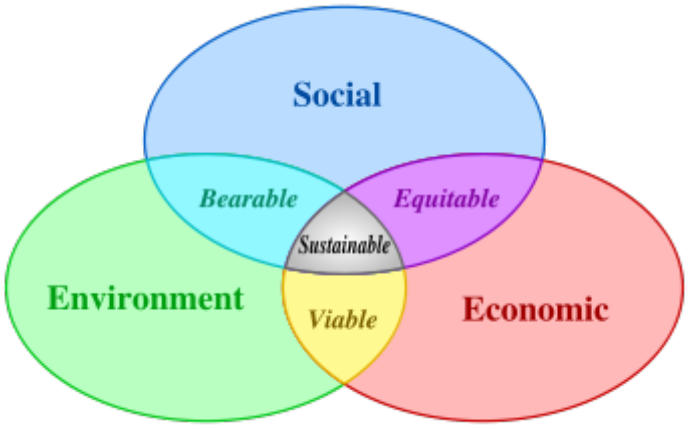
The Brundtland Report was the catalyst for the first United Nations Conference on Environment and Development held in Rio de Janeiro in 1992.

Our generally accepted definition of sustainable development originates from the Brundtland Report.

Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs.

Inset right:
Dr Gro Harlem Brundtland. Chair – United Nations World Commission on Environment and Development

The Brundtland Report established three recurring themes for sustainable development namely, environmental, economic and social factors.



Sustainability for the NHS and York Teaching Hospital NHS Foundation Trust

In January 2014, a document entitled ***"Sustainable, Resilient, Healthy People and Places. – A Sustainable Development Strategy for the NHS, Public Health and Social Care system"*** was published by the NHS Sustainable Development Unit.

It described the vision of a sustainable health and care system as a system which works within the available environmental and social resources, protecting and improving health now and for future generations.

This means working to reduce carbon emissions, minimising waste and pollution, making the best use of scarce resources, building resilience to a changing climate and nurturing community strengths and assets with the following goals:

- ***Goal 1 – A Healthier Environment*** contributing to better outcomes for all . This involves
    - Valuing and enhancing natural resources
    - Contributing to the Climate Change Act target with an ambition to reducing carbon emissions by 34% by 2020
- ***Goal 2- Communities and Services are Ready and Resilient for Changing Times and Climates*** which includes
    - Multi-agency planning and organisational collaboration for periods of heat, cold, flooding and other extreme weather events
    - Supporting vulnerable people and communities that suffer most
- ***Goal 3- Every Opportunity Contributes to Healthy Lives, Healthy Communities and Healthy Environments*** which involves
    - Helping to build immediate and longer term benefits of helping people to be well and reduce care needs
    - Improved information and more integrated approaches to minimise preventable ill-health, health inequalities and unnecessary treatment.
    - Supporting communities and people to be independent and self-manage conditions and events.

Whilst this NHS guidance has been updated since the Trust's Board set the mandate for Sustainable Development, the targets set at that time are still as relevant today as they were in 2009 with the exception of the updated 34% target reduction in carbon emissions by 2020.

What are the Benefits to the NHS of adopting a sustainable approach?

- A major part of sustainability is creating more efficient systems, minimising process waste and so delivering financial savings.
- Delivering a sustainable health system provides a positive vision for engaging with staff, external organisations and the public.
- A sustainable approach provides a common agenda for partnership working with all sectors in the region.

- Leading on this agenda sends a strong message to the people of the region that we believe in health promotion, social cohesion, justice and integrated person-centric cohesion.
- Unhealthy activities are often carbon intensive. Typically initiatives around health promotion, better diet, more exercise, reducing inequalities will reduce carbon. The agenda will drive carbon reduction and carbon reduction will help deliver the agenda.

NHS Sustainable Development Opinion:

- Sustainability and environmental management needs to become a cross functional consideration and be integrated with the Trust's strategy and decision making criteria.
- Technical solutions are only powerful if everyone understands them and can change their behaviour to maximise benefit.
- Building strong networks and exchanging knowledge and innovation is critical.
- Simply making buildings more energy efficient is not enough in the strategic long term.

Our Trust's ultimate objective is "***To be trusted to deliver safe, effective and sustainable healthcare within our communities."***

The Trust's values are

- Caring about what we do
- Respecting and valuing each other
- Listening in order to improve
- Always doing what we can to be helpful

How does sustainable development contribute to our Trust's adopted Strategic Frames:

We will promote safe, effective healthcare through implementing agreed standards to:	
Improve Quality & Safety - WE WILL:	
Ensure you feel cared for.	√
Encourage and act on feedback.	√
Develop the quality and skills of our workforce.	√
Keep you safe.	
Ensure no unnecessary waits or delays	
Ensure the right people are in the right place to meet care needs.	√
Learn from our mistakes and celebrate our successes.	√
Respect individual difference.	
Respect your privacy and dignity	
Develop stronger citizenship through our work with partners and the broader community – WE WILL:	
Seek opportunities to develop partnerships working for improved health outcomes	√
Enhance our reputation through our action, behaviours and performance to earn the respect of our community.	√

Support local businesses, voluntary organisations and communities.	√
Identify opportunities to engage with the community and add value.	√
Develop opportunities with our local communities to influence health decisions	√
Create a Culture of Continuous Improvement - WE WILL:	
Employ good staff, keep them and look after them.	√
Educate our workforce to meet changing needs.	√
Demonstrate value for money at all levels.	√
Deliver & surpass targets.	√
Achieve efficient use of resources, our staff, our money, our assets.	√
Actively develop leaders who will deliver the vision for service	√
Develop staff who uphold our standards and take personal responsibility for their work	√
Improve our facilities and protect the environment – WE WILL:	
Continually improve our buildings and facilities to meet changing needs.	√
Keep everything clean, tidy and safe.	
Make you feel welcome.	
Help you find your way around.	
Positively manage our impact on the environment.	√
Exploit the resources we have responsibly in order to deliver a sustainable future	√

[1]

11. Our Sustainable Development Commitments

Our Trust Board Sustainable Development Commitment - The overall mandate

In March 2009, York Teaching Hospital NHS Foundation Trust Board of Directors committed to the continuous improvement in minimising the impact of its activities on the environment and to becoming a good corporate citizen.

Our Trust Sustainable Development commitments are as follows:

- Comply with all relevant legislation
- Undertake the NHS Good Corporate Citizenship Assessment and develop action plans to improve performance.
- Achieve the carbon emissions reduction targets established by the NHS Carbon Reduction Strategy of 10% by 2015, 26% by 2020 and 80% by 2050 from a 2007 baseline and, where possible, exceed these targets.[1]
- Establish baselines for all relevant activities and set measurable objectives and targets using national measurement systems when and where available.
- Establish carbon/sustainability weighting to all investment/procurement options.
- Include climate change and the concomitant risk in the corporate risk register.
- Reduce/minimise environmental impact whilst maintaining continuous improvement.
- Integrate the principles of sustainability into all areas of Trust business.

Our Identified Supporting Actions are as follows:

- Ensuring the commitment made by the Board of Directors' is translated into clear direction and responsibility and that sustainable development is mainstreamed in the organisation's objectives, corporate strategy and annual report.
- Providing regular reports to Executive Board and Board of Directors and conducting reviews of policy.
- Developing and implementing reduction plans to address the major components of NHS carbon emissions including direct energy consumption, procurement, transport (including business, commuting and patient travel) and waste.

[1- The 2009 approved targets were to achieve NHS carbon emission targets of 10% by 2015 (the national NHS strategy said that this was from 2007 baseline) , 26% by 2020 and 80% by 2050 . These targets were re-stated in the 2015 report but have since been revised in national NHS guidance to 34% by 2020 from a 1990 baseline (which is stated to be equivalent for Health and Social Care England to 28% from a 2013 baseline), 50% by 2025, 64% by 2030, 80% by 2050.

These refreshed and existing targets will be considered in section 3.

- Using structured environmental auditing to review progress towards objectives.
- Implementing life cycle costings.
- Pursuing and active communication initiative to engage all staff, patients, visitors and others who visit/use our facilities.
- Providing training for all employees and contractors, especially in terms of sustainability, climate change and health and carbon literacy.
- Working closely with its partners, especially NHS organisations and local authorities, in developing whole community solutions to carbon emissions. The Trust will also work closely with regional and national agencies to develop leading practice in the field.

Our Commitment to the NHS Carbon Reduction Strategy

Our Sustainable Development Management Plan embraces and develops York Teaching Hospital NHS Foundation Trust Board of Directors commitment to adopting the NHS Carbon Reduction Strategy to be supported by progressive action plans to 2020 as a core objective.

The Carbon Reduction Strategy work streams are

- Energy and Carbon Management
- Procurement and Food
- Low Carbon Travel, Transport and Access
- Water
- Waste
- Designing the Built Environment
- Organisational and Workforce Development
- Role of Partnership and Networks
- Governance
- Finance

Many of these areas overlap with the Good Corporate Citizenship (GCC) Assessment model and whilst Appendix 2 provides comments against each area, it is proposed that the action plans going forwards are developed under the GCC headings making sure that all of the actions are covered by putting the work required under partnerships and networks within the community engagement heading and governance and finance under the heading of corporate approach, whilst noting that each of these also features as a sub-area within each of the domain areas.

Section 7 provides a summarised and integrated list of actions under the GCC headings.

Our Commitment to the Good Corporate Citizenship Assessment Model

Our Sustainable Development Management Plan embraces and develops York Teaching Hospital NHS Foundation Trust Board of Directors commitment to adopting the Good Corporate Citizenship Assessment Model to be supported with progressive action plans to 2020 as a core objective with the following targets:

- By 2015, the aim was achieve a score of 50% in each area. This means, on average, we should be saying yes to all “getting started” and “getting there” actions. (The score in 2014 was 24%)
- By 2020, our organisation should achieve a score of 75% in each area. This means, on average, we should be saying yes to all “getting started” and “getting there” actions and answering “yes” to at least half of the “excellent” questions

Good Corporate Citizenship Assessment Work streams are:

Corporate Approach
Travel
Procurement
Facilities Management
Workforce
Community Engagement
Buildings
Models of Care
Adaptation

Our Commitment to Adaptation to Climate Change

Our Sustainable Development Management Plan embraces and develops York Teaching Hospital NHS Foundation Trust Board of Directors commitment to developing and adopting an Adaptation Plan.

The Adaptation Plan will seek to prepare the Trust to respond to the demands presented by both the current and the projected impacts of climate change and adverse weather events.

12. Performance against the Carbon Reduction Targets

The 2009 approved targets were to achieve NHS ***carbon emission targets of 10% by 2015*** (the national NHS strategy said that this was from 2007 baseline)***, 26% by 2020 and 80% by 2050 .*** These targets were re-stated in the 2015 report but have since been revised in national NHS guidance to

- **34% by 2020** from a 1990 baseline (which is stated to be equivalent for Health and Social Care England to **28**% from a 2013 baseline)
- **50% by 2025**
- **64% by 2030**
- **80% by 2050**

It is therefore recommended that the Trust adopt replace the 2020 target of 26% with the revised recommendation of 34%.

General Update on Carbon reporting

This section of the report comments on the carbon footprint information included within the Appendices to this Sustainable Development Management Plan.

The carbon emission reporting is based on a number of sources, namley:

- Actual recorded data from a verifiable source, typically ERIC reporting.
- Modelled data inherent with the adopted Sustainable Development – Sustainability Reporting Framework Template
- Profiled data is used as a vehicle of last resort where none of the above categories can be adopted.

It is acknowledged that the carbon reporting outcomes are, therefore, not definitive. They are, however, the best reporting format available at this time and provide a basis for developing and prioritising carbon reduction opportunities.

Overall, the picture is one of increasing carbon emissions with a welcome downturn in 2014/15. Information for 2013/14 is compromised by the migration of properties from the former North Yorkshire and York Primary Care Trust.

The total measured Trust emissions for the base year of 2007/2008 are assessed to 74,751 tonnes CO2e. The total measured Trust emissions for the base year of 2014/2015 are assessed to 109,726 tonnes CO2e. This represent of an increase of plus 47% against a target reduction of minus 10%.

However, it should be noted that the number of patients have continued to rise since the baseline year and that the carbon savings per patient contacts have declined year on year giving an overall decrease of 29%. The total emissions however had a general trend which increased year on year until 2013/14 and, in 2013/14, a reduction in emissions was achieved.

Notable decreases have also been measured in relation to carbon emissions from energy within the last year which has achieved a 7 % reduction against the 2013/14 levels. These emissions will reduce further in 2016 as the completion of the Scarborough and Bridlington Carbon Energy Fund Projects which will realise further savings of a 15% reduction against 2014/15 Trust carbon energy savings) or will result in savings of at least 10% on energy emission from the baseline year . By comparison, information from the NHS Sustainable Development Unit has noted that there has been a 4.3% decrease in building energy carbon footprint across NHS Providers in England since the 2007/08 baseline with only a 1.4% reduction in the last year.

Whilst carbon emissions from energy are now reducing as a result of the Carbon Energy Fund programme at York, Scarborough and Bridlington, work must accelerate in relation to procurement as the growth in carbon emissions for the category has increased by 62% since the baseline year and is currently approximately 65% of the Trusts current carbon footprint. It is recognised that investment decisions must take account of and mitigate against rising carbon emissions

HM Treasury Scope Aggregations.

Between 2007/2008, the Trust total carbon emissions have increased year on year to 2013/14. 2013/14 coincides with migration to the Trust of properties from the former North Yorkshire and York Primary Care Trust. There is no reliable data back to 2007/08 for these properties in the data collection exercise. 2014/15 shows the first annual fall in carbon emissions over the monitoring period.

Scope 1 Emissions.

The Scope 1 gas and oil emission assessment is based on actual ERIC data submissions, with the exception of the former North Yorkshire and York Primary Care Trust, as discussed above. The Anaesthetic Gas emissions are modelled within the Sustainable Development – Sustainability Reporting Framework Template and is based on annual Trust turnover data. The 2013/14 to 2014/15 increase in carbon emission from gas usage is entirely predictable, coinciding with the generation of electricity at York Hospital using a gas fired Combined Heat and Power unit.

Scope 2 Emissions.

The Scope 2 electricity emission assessment is based on actual ERIC data submissions, with the exception of the former North Yorkshire and York Primary Care Trust, as discussed above. The 2013/14 2014/15 decrease in carbon emission from electricity usage is entirely predictable, coinciding with the generation of electricity at York Hospital using a gas fired Combined Heat and Power unit.

Scope 3 Emissions.

The Scope 3 Procurement emission assessment is based on two years actual Trust expenditure categorised to comply with the NHS standard Class E coding. The two years data includes 2013/14 and 2014/15. Procurement data for years prior to 2013/14 are profiled based on Trust turnover information. The actual/profiled procurement is modelled within the Sustainable Development – Sustainability Reporting Framework Template. Travel and Waste carbon emissions are similarly based Sustainable Development – Sustainability Reporting Framework Template modelling. Total Scope 3 emissions the Trust total carbon emissions have increased year on year to 2013/14. 2013/14 coincides with migration to the Trust of properties from the former North Yorkshire and York Primary Care Trust. 2014/15 shows the first annual fall in carbon emissions over the monitoring period.

Scope 3 Emissions – Travel

The Scope 3 Emissions – Travel data is an extract from the total Scope 3 emission information, discussed above. The assessment is based on a combination of robust and modelled data within the Sustainable Development – Sustainability Reporting Framework Template. Between 2007/2008, the Trust total carbon emissions have increased year on year to 2014/15. The increase in emissions is entirely due to “Other Travel- Patient and Visitor” and reflects the increase in patients treated within the Trust.

Scope 3 Emissions – Water.

The Scope 3 Emissions – Water data is an extract from the total Scope 3 emission information, discussed above. The assessment is based on a robust ERIC reported information modelled within the Sustainable Development – Sustainability Reporting Framework Template. Between 2007/2008, the Trust total carbon emissions have increased year on year to 2014/15.

Scope 3 Emissions – Waste.

The Scope 3 Waste – Waste data is an extract from the total Scope 3 emission information, discussed above. The assessment is based on a robust ERIC reported information modelled within the Sustainable Development –

Sustainability Reporting Framework Template. Between 2007/2008, the Trust total carbon emissions have significantly decreased year on year to 2014/15.

Procurement Carbon Footprint using eClass 2013/14.

The carbon emission associated with Scope 3 emissions – Procurement, based on eClass coding demonstrate the procurement streams responsible for emissions, by category. “Medical and Surgical Equipment” and “Building & Engineering Products & Services” are responsible for the largest contribution to carbon emissions.

Benchmarking Information – Organisation Carbon Footprint by Source.

This is generally discussed in HM Treasury Scope Aggregations above.

Benchmarking Information – Organisation Carbon Footprint by Population.

The annual carbon emission trend is generally falling with an observed anomaly in 2013/14 coinciding with migration of former North Yorkshire and York Primary Care Trust properties. Population number information adopted is based on information from CCG registered population data source.

Benchmarking Information – Organisation Carbon Footprint by GIA

The annual carbon emission trend is generally stable with an increasing tendency, due in part to the increases in clinical equipment to support patient care and treatment development demands. The anomaly in 2013/14 coinciding with migration of former North Yorkshire and York Primary Care Trust properties remains. GIA floor area information is robust, and is extracted from ERIC reporting information

Benchmarking Information – Organisation Carbon Footprint by Employee.

The annual carbon emission trend is generally stable with an increasing tendency. The anomaly in 2013/14 coinciding with migration of former North Yorkshire and York Primary Care Trust properties remains. Employee information is robust, and is extracted from ERIC reporting information

Benchmarking Information – Organisation Carbon Footprint by Occupied Bed.

The annual carbon emission trend is generally stable with an increasing tendency. The anomaly in 2013/14 coinciding with migration of former North

Yorkshire and York Primary Care Trust properties remains. Occupied Bed information is robust, and is extracted from ERIC reporting information.

Benchmarking Information – Organisation Carbon Footprint per Patient Contact.

The annual carbon emission trend is consistently reducing. The anomaly in 2013/14 coinciding with migration of former North Yorkshire and York Primary Care Trust properties remains, but is not obvious from the data set. Patient Contact is based on limited information from Trust reports, profiled in line with Population data.

13. NHS Carbon Reduction Strategy Progress

Many of these areas overlap with the Good Corporate Citizenship (GCC) Assessment model and whilst Appendix 2 provides comments against each area, it is proposed that the action plans going forwards are developed under the GCC headings making sure that all of the actions are covered by putting the work required under partnerships and networks within the community engagement heading, and, governance and finance under the heading of corporate approach, whilst noting that each of these also features as a sub part within each of the domain areas

14. Good Corporate Citizenship Progress

In 2015 the Board set the target for the Sustainable Development Group of achieving a 50% score for each of the Good Corporate Citizenship domains during 2015 (as recommended by the NHS Sustainable Development Unit).

The assessment tool prompts responses to a range of questions, from which an overall rating is developed. Within nine domains the organisation ranks itself from 'getting started', 'getting there' or 'excellent'.

There are 54 statements of intent against which progress is assessed for each of the domains, apart from Corporate Approach which has 9. The domains are as follows:

- Corporate Approach
- Travel
- Procurement
- Facilities Management
- Workforce
- Community Engagement
- Buildings
- Adaptation
- Models of Care

The Sustainable Development Group had assigned work stream leads for each of the domains, and they in turn have, in consultation with others where necessary, completed the assessment.

The completed assessments have been uploaded into a national database, held by the NHS SDU, which then allows the Trust access to others' data in order to benchmark. Appendix 6 provides a comparison of the Trust's performance score in each domain area.

The overall score that had been achieved in 2014 was 24%. The 2015 score achieved is now 33% and, whilst some areas have exceeded the target, two areas, models of care and adaptation which were new at the last assessment have made little progress due to staff changes and the absence of a domain lead . Only two areas have exceeded the target, procurement and workforce where some Trust–wide processes are in place and help achieve overall performance scores of 65% in both categories.

If the two most recently added domain areas, where little progress has been made are removed from the average calculation, the score would have been 43%, against a target of 50% It should also be noted that in 2014/15 only 19% or organisations used the GCC Assessment Model and these scored an average of 43% over the 9 sections. The NHS Sustainable Development Unit are in the process of updating the comparison data to consider those submitting since April 2015 and also reviewing their advice on targets.

Section 7 of the SDMP provides information on each domain area setting out the current position and the key actions proposed for 2016/17.

The NHS SDU suggested that Trusts should aim for a 50% score across all domains during 2015 and 75% by 2020 and so it is proposed that we set an overall target of achieving 60% by this time next year and that for each work stream, and asking the Sustainable Development Group to prepare action plans and monitor progress, reporting back to the Environment and Estates Committee quarterly with a six monthly report to the Board.

15. Adaptation to Climate Change Progress

The effects of climate change are likely to negatively impact the physical and mental health well-being of the UK population. Our health and care systems need to be prepared for different volumes and patterns of demand which are the result of the changing climate.

The system infrastructure (typically buildings, communications, emergency service vehicles, models of care) and supply chain (typically fuel, energy, food, care supplies) need to be prepared for and resilient to weather events and other crises.

The UK Climate Change Risk Assessment projects an increase in the frequency and intensity of weather related hazards. The UK[1] is predicted to experience much greater rainfall leading to flooding in the winter alongside drier summers with heat-waves and heightened air pollution. Headline risks include the impact of heat-waves and overheating of buildings, increased risks of air pollution and its associated health effects, and the increasing likelihood of flooding events, alongside impacts on service disruptions and communities.[2] The effects are expected to affect deprived people and groups the most.

Whilst it is recognised that the changing climate will impact upon our services, the overall rate of change for the next thirty years will be relatively slow, At the present time not all directorates have up to date business continuity plans which take account of periods of intense heat, cold, rainfall, or other adverse weather events and so this will be the focus of the coming year's work.

Adapting to climate change will encourage effective use of resources and therefore can save money and can deliver wider health benefits.

1. http://ukclimateprojections.metoffice.gov.uk/21678
2. www.sduhealth.org.uk/ARP

16. Current Summary Position and Priorities for 2016/17

This section summarises the work proposed to help to deliver SD within the Trust, within the constraints of the existing resources. **The bold actions are the ones which are the highest priority to deliver within the next 12 months**.

Work Stream Activities in 2014-2015 and Future Priorities, Actions and Targets

☐ *Corporate Approach*

Current Position

- The Director of Estates and Facilities leads and chairs the Sustainable Development (SD) Group
- The Sustainable Development Group has met 3 times within the last year
- The SD Group has shown an improvement of 9 % (achieving 33%) on the Good Corporate Citizenship Assessment.
- Sustainable Development activities featured in both the Strategy and Sustainability sections of the Trust Annual Report highlighting the recent successes of the Trusts Carbon Energy Fund Projects.
- This year the SD Group has looked in more detail at the Carbon emissions using the NHS Sustainable Development template in order to establish its baseline carbon emissions and highlight the areas where further work is required.

Key Actions for 2016/17
We will-

- Introduce an action plan with new KPIs for each work stream to demonstrate how a score of 60% can be achieved in 2016 on the Good Corporate Citizenship Assessment.
- Report on progress at least every six months to the Board
- Annually review the SDMP
- **Investigate the possibility of strengthening the mandatory section on Sustainability in Board template papers** emissions (through reducing energy from fossil fuels, reducing travel, reducing waste and reducing water use) and adapting to climate change are considered as part of any decision making process.
- **Develop a Sustainable Development Communication and Engagement Plan**
- Achieve an overall 60% score on GCC in 2016/17, and compare with other acute Trusts to become one of the top organisations. Provisional targets also set for future years

- o At least 60% in 7 out of 9 domain areas in 2017/18,
- o At least 70% on 2018/19
- o At least 75% by 2019/20

⧠ *Travel*

Current Position

- Travel plan has been developed for York and Scarborough
- Pool and lease cars in use at York and Scarborough which reduce costs and carbon emissions
- Monthly reports provided on private car business mileage + pool car mileage and use

Key Actions for 2016/17

We will-

- **Develop a Trust wide travel plan –incorporating site specific plans for all main sites. The plan will incorporate actions to reduce carbon emissions through modal shift and procurement and the promotion of healthy and sustainable travel options.**
- Deliver electric vehicles infrastructure initially procuring 9 electric fleet vans
- Improve website information for patients and staff, including information on travel options and Trust wide parking arrangements.
- Improve monitoring information across the Trust to incorporate business mileage by transport mode including car sharing to show miles avoided and reduction in carbon emissions

⧠ *Procurement*

Current Position

- Procurement Policy incorporates the requirements of the Public Services (Social Value) Act for Trust to consider how their procurements will improve the economic, social and environmental well-being.
- Procurement Strategy published on Staff Room/intranet and includes sustainable and ethical elements
- E- learning sustainable procurement learning is available to all on the intranet
- Senior leadership team and middle level staff are MCIPS qualified (Chartered Institute of Purchasing and Supply).
- New Selby War Memorial Hospital used Government Buying Standards to achieve a BREEAM “Excellent” accreditation.
- New products and services assessed through a number of groups for their overall impact on the Trust. These are the MESSE group (Medical/Surgical, Supplies and Equipment) who focus their efforts on everyday consumable items and the MERG Group (Medical

Equipment Resource Group) who focus their efforts on medical devices and furniture.
- Whole life costing an integral part of Procurement for EU Tenders

Key Actions for 2016/17
We will-

- Ensure that all procurement staff undertake sustainable procurement training
- Encourage end user requisitioners to undertake free sustainable procurement training available via the intranet
- **Develop a set of sustainable procurement objectives with success measured by metrics including how procurement decisions reduce energy and water use and reduce waste**
- **Complete assessment of at least the top 28 suppliers (who make up 50% of everything sourced) to assess the impact on our sustainable development objectives covering all the GCC themes and encourage them to report and reduce their impact on carbon emissions, minimising travel, local sourcing, waste reduction, limiting** the use and impact on resources through re-use and recycling.
- Continue engagement with SMEs and local suppliers and support them to win business with the Trust by them demonstrating their commitment to reducing environmental impacts, improving quality, fairness and sustainability
- Add the "Procurement for Carbon Reduction" (P4CR) Flexible Framework as part of the next Procurement Strategy as a means of developing carbon weighted investment impacts and reducing procurement carbon emissions
- Promote the use of the SDU's energy efficiency of medical devices tool: An Excel- based tool designed to help users assess the energy efficiency of medical devices.

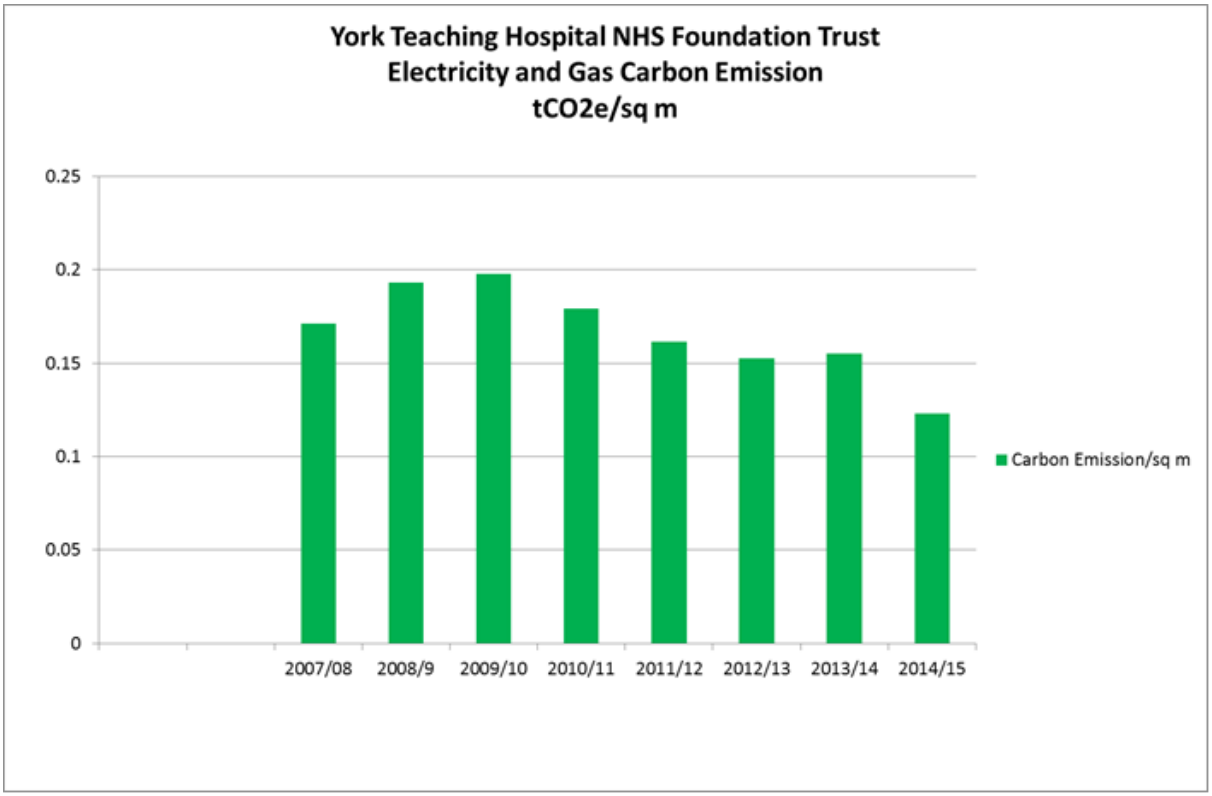
Facilities Management

Current Position

- Recycling Strategy developed which also encourages waste reduction
- General and confidential waste at major sites is now recycled into tissue paper
- We have signed up to the Public Health Catering Responsibility pledge with the aim being to provide healthier choices within our Trust restaurants and to encourage people to choose a healthier diet and help improve public health
- Food and Drink Strategy includes commitment to sustainable procurement
- We have a comprehensive prioritised energy saving and carbon reduction plan for the three major acute hospitals which are the biggest

energy users and carbon emitters within the Trust. Carbon Energy Fund Project completed at York Hospital and close to completion at Scarborough and Bridlington

- Carbon Energy Fund Project at York is achieving significant savings – The table below demonstrates a 28% reduction in carbon emissions per square metre from 2007/8 to 2014-15 for the Trust as a whole. A significant reduction is demonstrated in 2014/15 due mainly to the Carbon Energy Fund Project at York Hospital Project at York Hospital



Key Actions for 2016/17
We will-

- Communicate and promote sustainable operations throughout the estate through staff workshops to establish ownership of actions to reduce energy use and carbon emissions, reducing waste, travel and chemical impacts and supporting local biodiversity
- Continue to report on progress being made in relation to carbon reduction at least every six months to the Board (via the Environment and Estates Committee)
- **Complete the CEF Project at Scarborough and Bridlington Hospitals realising a further carbon emissions saving of 3,000 tonnes CO2e**
- Plans to be developed for top ten carbon emitting Trust premises based on individual energy surveys, to be implemented over a five year period subject to resources and capital fund availability

- **Update and complete the Waste Management Plan** which aims to prevent, reduce and recycle waste and so reduce waste to landfill.
- Investigate the possibility of developing Sustainability and Waste awareness through induction and Statutory/Mandatory training
- Review water use including practices for Legionella control to develop plans to reduce water demand and improve water efficiency
- Improve monitoring of Hazardous substances and chemicals in order to be able to demonstrate that our practices are leading to a continual reduction in absolute levels of hazardous substances and chemicals

Workforce

Current Position

- Business case template includes a section to review impact on sustainability
- Apprenticeships schemes available and work with Job Centre Plus to recruit staff from "return to work" schemes
- Trust has Staff Health, Well- being and Engagement Strategy with a three year action plan and a Steering Group
- The Trust was deemed an Exemplar Organisation in staff health and wellbeing by NHS England in 2015. This has resulted in our Trust piloting further initiatives for NHS England to further improve staff health and wellbeing
- Trust offers Flexible Working Policy, Special Leave Policy and childcare vouchers which help to accommodate and support the specific needs of parents and carers
- Trust has a Staff Suggestion Scheme (SHINE) and a "You said, We did" communication and engagement campaign, Staff/Director Surgeries

Key Actions for 2016/17

We will-

- **Investigate the possibility of incorporating Sustainable Development objectives into the staff and Board induction process and through mandatory training and Leadership Programme for continuing staff and Board learning & development**
- **Incorporate commitment to sustainability, reducing carbon emissions and corporate social responsibility in all staff, senior managers' and directors' job descriptions and link this through the appraisal process.**
- Encourage local skills and education providers to include sustainable development in their programmes
- Investigate the possibility of delivering Trust wide proposals for mentoring beyond the current pilot stage for young people in education

- Develop monitoring to demonstrate the impact of child care and carer support on recruitment and retention
- Implement initiatives from the NHS England Staff Health and Wellbeing pilot e.g. Introduce Health Assessments for staff aged 40plus with sign-posting and six monthly follow-up appointments

☐ *Community Engagement*

Current Position

- Corporate Communication and Engagement Plan (Board approved in September 2015) revised which complements and works alongside the Membership Development Strategy, Patient Experience Strategy, Fundraising Strategy, Staff Engagement Strategy. The Strategy recognises that engagement is important both for our organisation and services in helping our local population to build healthy, sustainable lives and communities.

Key Actions for 2016/17
We will-

- **Develop a Sustainable Development Communication and Engagement Plan, to incorporate participation in national campaigns such as NHS Sustainability Day, Climate Week, Energy Saving Week, Green Office Week (April 2016)**
- Establish a network of sustainability champions and projects. (July 2016)
- Seek to introduce a "Sustainability Star" Award
- Improve engagement with partners on sustainable development work by seeking Sustainable Development leads with partner organisations e.g. through Board to Board Meetings. (April 2016)
- Develop Sustainability information on the website and via other means which encourages the public and staff to offer ideas on how to improve our environment and sustainability (July 2017)
- Investigate opportunities to ensure patients/users/clients are given information about the sustainability of their choices, for example in making healthy and sustainable food choices and in self-management practices (December 2016)

☐ *Buildings*

Current Position

- Framework contracts with design team and minor works contractor had sustainability as a key criterion for assessment during the tender analysis phase. P21+ Principal Supply Chain Partner engaged with KPIs linked to sustainability

- 6 Facet survey completed, which includes an assessment of building performance.
- Information provided at a high level in the Trust annual report

Key Actions for 2016/17
We will-

- Ensure that the 6 facet survey is kept up to date by the Estates team
- **Develop a sustainable building strategy as part of revised capital project procedures**
- **Develop a capital project procedure that clearly sets out the objectives to achieve BREEAM "Excellent"/ "Very Good", including the need to gain "innovation credits" in the field of sustainable performance by incorporating innovative technology where practicably feasible and economically viable to do so.**
- **Introduce regular reporting on building sustainably to the Capital Programme Executive Group**
- Develop more formal checklists/ processes within the overall capital projects suite of procedures to ensure that health and sustainability consideration, including adaptation to climate change for the buildings/ assets, together with green space and biodiversity considerations, are captured during the design and delivery stages of our buildings and refurbishment projects
- Develop a formal measuring and monitoring system incorporating KPIs for social, economic and environmental impacts of capital projects for reporting to the Trust's Sustainable Development Group
- Engage with local authorities and local communities from the outset of new projects, involving them in the planning and design of buildings and refurbishments, including
    - formalising the engagement of planning authorities at the pre-planning submission stage via revised capital project procedures
    - Family and friends test on environment and design
    - Capital projects surveys for staff patients and visitors
- Become a leading example of sustainable design and implementation in our new building and refurbishment projects including consideration of life cycle costing and minimising environmental impacts, ensuring that we demonstrate and communicate performance/ delivery achievements through measures such as energy use sub-metering at individual ward or departmental sub-level (where practicable) and Building Energy Management systems which support procedures to minimise carbon emissions both at the design stage and "in-use".

Adaptation to Climate Change

Current Position

- Our Sustainable Development Management Plan embraces and develops the York NHS Foundation Trust Board of Directors Commitment to developing and adopting an Adaptation Plan

- Plans for Heat Waves and Cold Weather have been developed and continue to be reviewed and updated
- Community Risk Register uses Environment Agency current flood risk assessments
- Corporate Emergency Planning and Business Continuity Planning Guidance developed and is available on Staff Room (intranet)
- Some directorates have business continuity plans which include plans for disruption due to weather

Key Actions for 2016/17
We will-

- Encourage completion /review of business continuity plans which require consideration of the consequences arising from current disruptive weather events and raise awareness of longer term trends
- Update formal Capital Projects checklists / processes to incorporate measures that will enable the buildings / asset s to adapt to climate change.
- Encourage links with partners to embed Climate Change in local thinking and long term decision making.

⧠ *Models of Care*

Current Position

- The Trust's ultimate objective is "***To be trusted to deliver safe, effective and sustainable healthcare within our communities***"
- Partnership working with City of York and Selby District Councils to install free loft and cavity wall insulation to out of hospital patients suffering from cold related health conditions

Key Actions for 2016/17 (TBC)
We will-

- Give consideration to reviewing education programme for clinical and care staff to determine whether additional consideration is required on how they can contribute to sustainable healthcare including reducing the carbon and environmental impacts in service delivery areas
- **Seek to ensure that sustainability and achieving sustainable models of care become part of the clinical care lead responsibility including reducing carbon emissions of service delivery (and or other sustainability metric)**
- Give consideration to reviewing everyday advice and procedures
- Seek to develop an action plan
    - To ensure that we have plans to improve physical and mental health including taking every opportunity to educate staff and

patients/ users/clients about the benefits of healthy lifestyles (including improved nutrition, exercise and a healthy work environment)

- To provide more empowering care by exploring financially and environmentally sustainable models of care particularly in relation to chronic disease and elderly care management, to reduce attendance through the use of interaction with a range of communication technology
- To provide care closer to home through support mechanisms for vulnerable people in our communities
- To improve the efficiency by regularly benchmarking and reviewing our services in terms of use of resources, reduction in waste and carbon emissions

Appendix 1 – Good Corporate Citizenship Assessment Action Plan

Good Corporate Citizenship Assessment Model			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Nominate Good Corporate Citizenship Assessment Model Work stream leads.	Via Sustainable Development Group.- Reviewed in 2015/16 due to staff changes (some overlap noted with PAM and PLACE work)	December 2015	Leads still to be agreed for Models of Care, Facilities and Adaptation
Adopt Sustainable Development Unit Good Corporate Citizenship Assessment Model targets.	Via Sustainable Development Group.	July 15	Complete
Routinely report Good Corporate Citizenship Assessment Model progress on the Sustainable Development Unit web site.	GCC Assessment undertaken in 2014 – 24% score achieved in 2014, 33% score in 2015 Current NHS SD targets are to achieve • 50% by 2015 • 75% by 2020	At least annually	Review progress on six monthly basis
Report annually to staff, the public and other stakeholders.	Via Environment and Estates Committee and annual Sustainable Development Report from SD Group Trust Annual Report and Accounts Board Report – to include SD work in Strategy section and also Statutory Information section on sustainability	Annually	E &E Committee – Dec 15 Board report information to be completed by April 2016

Appendix 2 – NHS Carbon Reduction Strategy Action Plans

1. Energy and Carbon Management			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Develop and implement a robust Energy Management System. The Energy Management Systems shall be subject to annual review.	Develop and adopt an Energy Management System based on BS EN 16001:2009.	February 2016	Basic planning and draft format completed.
Undertake regular Board level reviews of performance in energy efficiency and carbon reduction. To be reported annually to staff, the public and other stakeholders.	Energy and carbon emission budgets established for each Financial Year. Monthly performance reporting delivered including current month, year to date information and floor area benchmarking. Wider reporting options to be reviewed and adopted.	Complete. April 2016	 Options under review.
Carbon measurements to replace energy measurements as the target for reduction throughout our Trust.	Confirmation from Trust that this requirement aspiration is viable at this time. . Business Case policies and procedures to be aligned with aspirations.	To be agreed	
Develop and implement strategic plans to provide resilient and renewable energy sources. Ensure a guaranteed energy	Individual property energy surveys to be completed. Format to be developed.	March 2016	Planning stage only.

supply, whilst managing an overall carbon footprint.	Cost effective opportunities at property level to be identified and capital funding to be sought.	Post March 2016	
Capital developments to be assessed on a whole life cost basis for all capital developments.	Confirmation from Trust that this requirement aspiration is viable at this time. Mechanisms to be developed and agreed with Capital Planning. Business Case policies and procedures to be aligned with aspirations	To be agreed	
Empower staff to take responsibility for carbon reduction and energy consumption.	Behavioural Change strategy to be developed, agreed and implemented.	To be agreed	Planning stage only.

2. Procurement and Food			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Manage operation and procurement efficiently, minimising wastage and carbon from the outset.	Items are catalogued (NHSSC 100%, Oracle 92%) so that end users are directed towards approved items. Where possible items are assessed and use avoided (if a suitable process can be used so a product does not need to be e.g. washing hands rather than wearing gloves) but where products are required they are consolidated to reduce the number of delivery miles. The hospital (at York) has a mature system of Materials Management whereby waste is minimised by only ordering what is required on a weekly basis. 27 suppliers make up 50% of the consumables and services spending for the Trust.		
Our Trust shall work in partnership with suppliers to improve sustainable and low carbon production.	We have the sustainability plan of our largest supplier and have plans to seek them from the others who make up the top 50%. We have been working with our largest suppliers who, in turn, work with their suppliers to re-specify lower resource and/or lower carbon alternatives to common products. (e.g. syringes – now 30% less raw materials)	March 16 (Top 10)	

Local procurement, whole lifecycle costs and the environmental impact of financial decisions shall be considered by our Trust preparations taken to embrace carbon as a currency.	Whole life costing has been used for a number of years to assess tenders. The tender report has been rewritten to include the social, environmental and economic benefits of the procurement and these are reported to the CEO. The document is available from the Intranet for all to use. If the costs of carbon are known then we can use this as a currency (or value) in the financial analysis within a tender evaluation and make informed choices.		
Undertake a review of the carbon footprint associated with the procurement of pharmaceuticals and implement actions to produce significant reductions.	The 2014/15 analysis in being undertaken. (Sadly) invoices are not coded to NSV (National Supplier Vocabulary) so the associations become more difficult to ascertain. We are trying to rewrite a computer report to try and extract this data.	Dec 15	
Promote sustainable food and nutrition.	We have been looking at the feasibility of a super-tender (as our milk and bread contract runs out in December) to cover all Provisions. Within this tender the criteria will include impact on the environment, sustainability and social value. Nutrition is managed within Dietetics but we can include criteria to reducing fat and sugar.	March 16	

3. Low Carbon Travel, Transport and Access			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Develop a Board approved travel plan	Currently the Trust has a Travel Plan for both acute sites and Malton; however the plan is to develop a Trust Travel Plan that makes reference via an appendix to all Trust sites. Bridlington site is just being surveyed an plan	2016 (approx 1st April)	Ongoing

	created		
Introduce a flat rate for business mileage regardless of engine size, extend the review to travel options (car, train, bus, cycle and foot) and make recommendations to the Board.	This has been introduced as per the travel and subsistence policy. The travel option has been identified in an easy to follow flow chart within the Policy. This enables the staff member to plan the most efficient and cost effective journey Car share, pool car, public transport and active travel are all promoted to staff and patient/visitors.	On-going	
Establish consistent monitoring arrangements and reduce emissions from road vehicles used for Trust business.	Electric Vehicles will be implemented and the emissions monitored, the Trust pool car fleet are monitored and reported on a monthly basis. With regards to business lease or employee owned vehicles, finance team to confirm.	On-going	On-going
Establish mechanisms to routinely and systematically review the need for staff, patients and visitors to travel.	Currently the Trust is drafting a staff, patient and visitor survey that will establish the current travel demand and future needs in regards to Travel. This will be an annual survey that will incorporate an action plan based on the findings which will form the basis for the following survey to ensure progress is shown.	01/02/2016	At draft stage
Work towards the delivery of Healthcare closer to patients' homes.	The Trust has introduced Coms hubs that provide patient care closer to home. In addition, the Occupational Therapist Teams and Maternity have invested in department cars and use pool cars to visit patients at home providing valuable care and support. This is an extremely cost effective and efficient way of working while ensuring the patient receives quality care in a familiar and environment with little disruption.	On-going	On-going

4. Water			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Integrate the efficient use of water into building developments at design stage.	Work with capital planning teams	On-going	
Measure and monitor water costs and consumption. Report annually to staff, patients and the public.	BG2 provides this Staff matters	On-going Sept 15	
Identify water leaks throughout our Trust infrastructure and fix as a service level priority.	Doing this (Scarborough example)	On-going	
Adopt water efficiency technology as a standard.	On-going but there is a conflict with control of legionella & pseudomonas	On-going	
Avoid the routine purchasing of bottled water.	Banned this several years ago , and also remover water coolers as part of the risk assessments to control legionella etc.	Done	

5. Waste			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Review levels of waste disposal, re-use and recycling and report annually to staff, the public and other stakeholders.	Recycling strategy document prepared . Article in staff matters.	Done July 15	
Undertake a balanced risk assessment of all waste and its associated carbon emissions/costs, including those related to “single issue equipment” use.	Consider in conjunction with procurement action plan		
Ensure that we have the necessary skills to manage waste legally, efficiently and cost effectively.	Trust wide Waste Manager working towards NVQ Level 4 (tbc Jan 16) . Staff trained	Jan 16	
Monitor the quantity and cost of all waste streams (waste from clinical areas, hazardous waste, domestic waste to landfill) and set trajectories to monitor, manage and reduce them over time.	ERIC returns Estates & Facilities monthly reports Recycling strategy document Target set at 80% for all work streams apart from clinical waste by Apr 2016 .	Apr 16	
Monitor, manage and increase re-use/recycling.	ERIC returns Est & Fac monthly reports	ongoing	

6. Designing the Built Environment			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Design all new buildings and major refurbishments within our Trust to withstand significant climate change and weather extremes.	Revised Capital Projects Team procedures to include checklist requirements for ensuring that all new buildings and major refurbishments within our Trust to withstand significant climate change and weather extremes. – taking account of best practice, statutory requirements, BREEAM guidelines, Carbon Trust guidance etc.	6 months and thereafter on-going	Live
Aim to all new to achieve low carbon targets for all new buildings.	Revised Capital Projects Team procedures to include checklist requirements for consideration of low carbon technologies and BREEAM criteria when working through the detailed design stage for new building projects (and refurbishment projects where feasible and appropriate).	6 months and thereafter on-going	Live
All decisions about the design and build of healthcare buildings within our Trust to be explicit about how they deliver a broader approach to sustainability including transport, delivery of services and community engagement.	Revised Capital Projects Team procedures to include checklist requirements for consideration of how the design and build of healthcare buildings within the Trust deliver other aspects of the sustainability agenda (to include transport, delivery of services and community engagement etc). For example, one of the requirements for new build and major refurbishment projects, particularly those driven by operational changes to clinical services,, will be the need to carry out formal parking impact assessments and revisions to the travel plans for the site where the development is taking place in order to mitigate any potential impact of the service changes on the sustainability work in the Trust. Similarly, at the planning stage of for new build and major	6 months and thereafter on-going	Live

	refurbishment projects, particularly those driven by operational changes to clinical services, the Capital Projects team will ensure that consideration is given to transport issues and issues of accessibility to the services (parking provision, public transport arrangements.		
Recognises that buildings need to move quickly to have a lower carbon impact, not only in their construction but also in their lifetime use and decommissioning. Buildings shall be designed to promote sustainable behaviours in staff, patients and visitors and they shall be adaptable so as to support change towards low carbon patient pathways.	Revised Capital Projects Team procedures to include checklist requirements for consideration of how to reduce the carbon impact of the Trust's healthcare estate – not only during the construction phase of their lifecycle but throughout the remainder of their lifecycle through to their de-commissioning. The revised procedures will be drawn from best practice, statutory requirements, BREEAM guidelines, Carbon Trust guidance etc. For example, off-site construction using low carbon technologies and materials will be given full consideration during the design stage for new build and major refurbishment projects. Similarly the revised capital projects procedures will ensure that the design process for new build and major refurbishment projects will promote sustainable behaviours in building users (e.g. by developing intelligent building technologies in our buildings) and ensure that as far as possible new facilities are as flexible and future-proof as possible.	6 months and thereafter on-going	Live

7. Organisational and Workforce Development			
Core Objective	**Action**	Action Timescale	**Action Status**
Future leadership development shall embrace competencies that are required to deliver carbon reduction.	• Train/educate Trust trainers in Sustainability and the link to leadership development. Request the new Sustainability Manager to provide the education/training • CLAD/OD to incorporate sustainability in Leadership		

	development *<u>Update as at 2/11/15:</u>* • *Meeting arranged with Gail Dunning, Anne Devaney, Jane Money & Dawn Preece on 18/11/15 to discuss above points and how the objective can be achieved (e.g. do we incorporate into current programmes or do separate sessions, consider induction, e-learning, develop a tool kit, appraisal training)*		
Work in partnership with Higher Education Institutions to ensure that sustainability and carbon reduction concepts are included in under graduate curricula.	• Train/educate key stakeholders in Sustainability (OD and Post Graduate Department). Request the new Sustainability Manager to provide the education/training • OD and Post grad to take forward *<u>Update as at 2/11/15:</u>* • *Meeting arranged with Gail Dunning, Anne Devaney, Jane Money & Dawn Preece on 18/11/15 to discuss above points and how the objective can be achieved*		
Sustainability and carbon governance responsibility to be included on all job descriptions for Chief Executive and Director posts and on all descriptions for staff positions.	• Add to job descriptions of Director level as part of their annual review • Add to job description template for all new and revised posts • Link updated job description template to staff appraisal process *<u>Update as at 2/11/15:</u>* • *Draft wording compiled for job descriptions and sent to*	April 2016 Dec 2015 Dec 2015	

	Jane Money for checking on 2/11/15		
Ensure that our staff have information about and opportunities to use low carbon travel options.	• This objective links to Objective 3 which will be taken forward by Zara Ridge as the identified lead who will engage with key stakeholders *<u>Update as at 2/11/15:</u>* • *Meeting arranged with Zara Ridge & Dawn Preece for 23/11/15 to discuss how bring together all aspects of low carbon travel options and the best way to share with staff (e.g. A4 guidance sheet issued) at the appropriate points (e.g. when issued with car park permit, Staff Benefits, induction pack)*		
Audio, video and web conferencing technology to be made available and staff shall be trained in these technologies to support a cultural shift from routine care and other high carbon travel. Encourage more home working.	• Home Working Guidance to be revised and launched with a link to the sustainability agenda *<u>Update as at 2/11/15:</u>* • *Discussion to take place with author of Home Working Guidance to agree how take above forward.* • Liaise with Systems & Networks to do staff communication and training on technologies available *<u>Update as at 2/11/15:</u>* • *Meeting organised with Adrian Shakeshaft, IT and*	Dec 2015 TBC OD staff to be trained by April 2015 & then pilot with next leadership programme	

	Dawn Preece for 11/11/15 to discuss above action. • OD to progress Web ex project to enable action learning, meetings etc. to be conducted using available technologies *<u>Update as at 2/11/15:</u>* • *Discuss this at meeting with Gail Dunning on 18/11/15*		

8. Role of Partnership and Networks			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Exert influence within local frameworks and support carbon reduction.	1. Local organisations invited to attend and Travel & Transport Group meetings. CYC now to attend Sustainable Development Group meetings and terms of reference reviewed. 2. Links with CYC being strengthened through new project feasibility work	Oct 15	1. Complete 2. On -going
Actively pursue climate change action within our Local Strategic Partnerships	1. Develop existing links with NYCC, CYC and ERC and partnership work with Health and Wellbeing Boards to explore to delivery of a shared commitment to Climate Change and, Sustainable Development	April 2016	Work started with CYC, other areas to be explored through GCC domain areas and partnership leads
Support the NHS and Department of Health regional sustainable development frameworks to ensure wide representation across organisations and frameworks.	1. Attend SD leads Network Meetings 2. Provide best practice presentations to others 3. Involved in Joseph Rowntree Foundation Anchor Institutions research project on tackling poverty through action on procurement, recruitment and employment	On-going.	1.Last Regional Conference in Leeds on 24/9/2015 2. National Performance Advisory Network received presentation on York Trust Carbon Energy Saving Project
Review our role within local partnerships and networks and report annually to staff, the public and other stakeholders.	1. See above on links with other organisations. 2. Review list of partnerships and develop reporting and engagement through Communication Plan. 3. Annual Report to Environment and Estates Committee	1.April 2016 2. February 2016 3.	1.On going 2. Action required 3. Draft prepared
Lead on sustainable development	Promoting CEF Project - National Performance	On-going	Give consideration to

and carbon reduction and aspire to be an exemplar to other sectors and to other health systems.	Advisory Network received presentation on York Trust Carbon Energy Saving Project. Sustainable Development information with details of Trust Energy/Carbon Saving information at Citizen's Advice Big Energy Saving Week Drop-in session at the Hub on 28th October 2015. Electric Vehicle demonstration day at York Hospital Involved in NHS SS Unit Metrics Steering Group		developing Case Studies for SD Unit and also enter National Sustainability Day Competitions

9. Governance			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Sign up to the NHS Good Corporate Citizenship Assessment Model and produce a Board approved Sustainable Development Management Plan which shall establish clear, measurable milestones.	Sustainable Development Management Plan was received and endorsed by the Board of Directors in January 15. GCC Assessment undertaken in 2014 – 24% score achieved NHS SD targets are to achieve • 50% by 2015 • 75% by 2020 Action plans under development with domain leads- many of which contain specific targets	Jan. 15	Complete
Establish targets and trajectories to meet the provisions of the Climate Change Act. In the first instance to be 10% of 2007 levels by 2015, as a minimum.	SD Management Plan sets carbon reduction targets of • 10% by 2015 • 26% by 2020 (now revised on the NHS SDU site to be 28% from a 2013 baseline which is equivalent to 34% from a 1990 baseline) • 80% by 2050	Jan 15	Complete
Carbon reduction and sustainable	Included within Business Case pro-formas but more work		Under

development to be corporate responsibilities and an inherent part of performance and governance mechanisms.	required to ensure that this is followed up at the post-business case review. Responsibilities to be integrated into all job descriptions. Raise awareness of the Trusts Strategic Frames which include the need to • positively manage our impact on the environment. • Achieve efficient use of resources • Exploit the resources that we have responsibly in order to deliver a sustainable future	Jan 16	development
Make sustainability and environmental impact an integral element of quality standards.	The Annual Report and Accounts for 2014-15 Board Report states that the Trust's ultimate objective is "**To be trusted to deliver safe, effective and sustainable healthcare to our communities"** To be delivered through Sustainable Development Group and the actions plans from the domain leads.	Jan 16	Action plans to be developed following completion of GCC assessment review in 2015

10. Finance			
Core Objective	**Action**	**Action Timescale**	**Action Status**
Develop carbon literacy and embed carbon reduction in our financial mechanisms.	The Business Case process has been updated to reference the sustainability agenda, raising awareness of carbon reduction requirements and introducing carbon reduction to our financial processes.	Immediately	Complete
Identify and take advantage of schemes that support investment in energy efficiency initiatives.	The Business Case process has been redesigned to include a specific section to draw out the benefits of energy reduction schemes. The Trust has prioritised two major carbon	Immediately	On-going

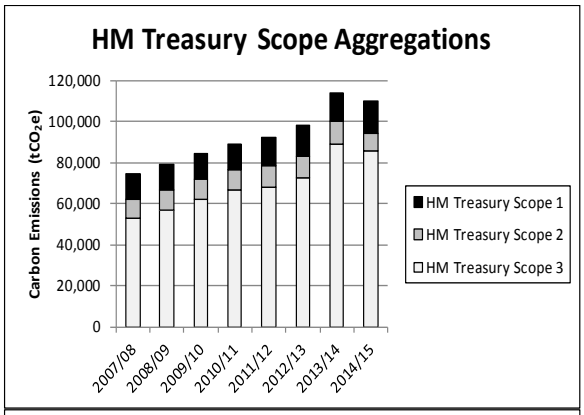
	reduction/energy efficient schemes recently – the CHP at York and the CHP and Scarborough.		
Be involved in local strategic partnership arrangements and regional economic forums in order to play a part in developing a sustainable and resilient health economy.	Through the Trust's Sustainable Development Group consideration will be given to local strategic partnership development to ensure the Trust plays a part in developing a sustainable and resilient local health economy.	Immediately	On-going

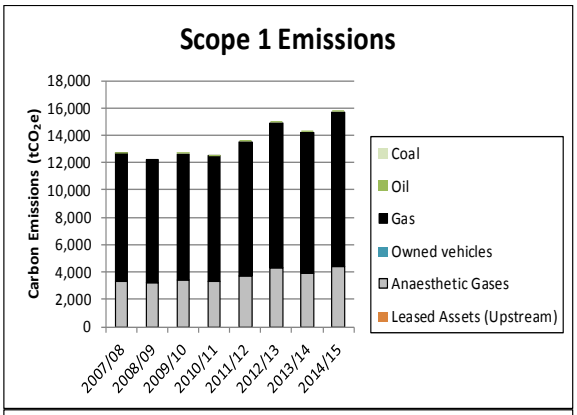
Appendix 3 – Adaptation Action Plans

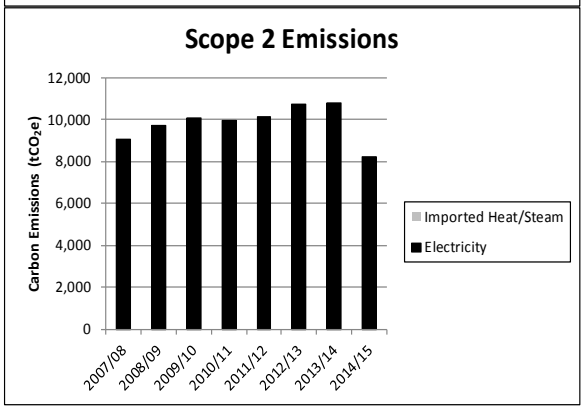
Adaptation Plan			
Core Objective	Action	Action Timescale	Action Status
Include Adaptation within Emergency Preparedness Plans and Business Continuity Plans.	Include Adaptation and response to adverse weather events within Emergency Preparedness Plans and Business Continuity Plans.	June 2016	On-going
Develop partnerships with Local Authorities and other stakeholders.	Sustainability Manager to investigate leads on adaptation agenda from other local authority partners and other stakeholders and investigate the opportunities for a coordinate approach		
Incorporate mechanisms for review and update within the Adaptation Plan	Develop adaptation plans through Capital Programme and Departmental Business Continuity		
Align with local community plans.	Develop through links with Local Authorities		
Include climate change risk in the organisational risk register.	Add to corporate risk register . BG1/JM		

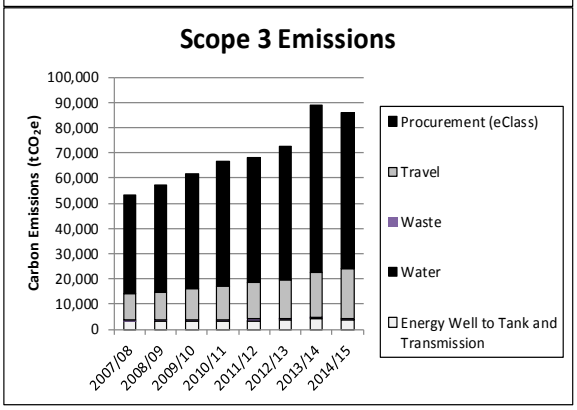
Appendix 4 – NHS Carbon Reduction Strategy Reporting

Carbon Emissions Progress Report: 2014-2015









Overall Progress

CO_2 Emissions (tCO_2e)		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
HM Treasury	Total	74,751	78,966	84,522	88,932	91,966	98,060	114,088	109,726
	Scope 1	12,718	12,195	12,652	12,513	13,591	14,936	14,277	15,734
	Scope 2	9,024	9,730	10,068	9,962	10,144	10,724	10,811	8,220
	Scope 3	53,009	57,042	61,802	66,456	68,231	72,400	88,999	85,772

Scope 1 - Direct

CO_2 Emissions (tCO_2e)		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Scope 1 - Direct	Total	12,718	12,195	12,652	12,513	13,591	14,936	14,277	15,734
Owned buildings	Gas	9,366	8,945	9,253	9,108	9,772	10,559	10,266	11,353
	Oil	50	0	6	38	56	26	58	8
	Coal	0	0	0	0	0	0	0	0
Leased Assets (Upstream)	(Gas, Electricity, Coal)	0	0	0	0	0	0	0	0
Owned vehicles		0	0	0	0	0	0	0	0
Anaesthetic Gases		3,303	3,249	3,394	3,367	3,762	4,351	3,952	4,374

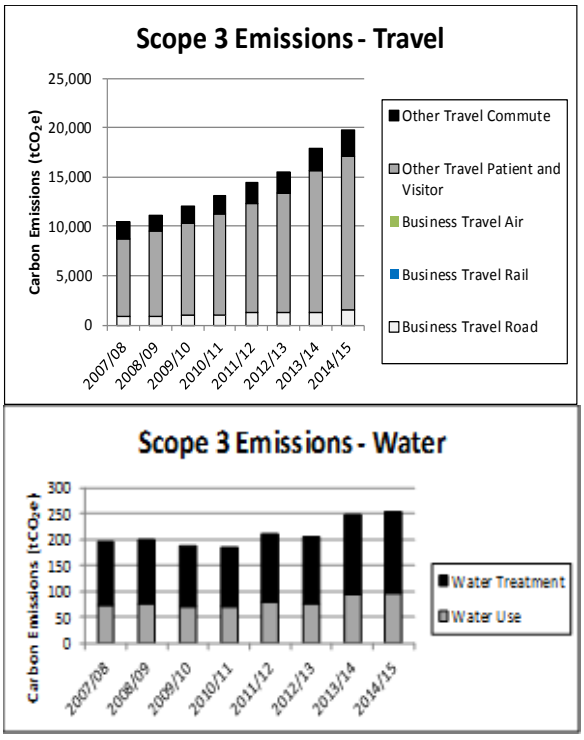
Scope 2 - Indirect

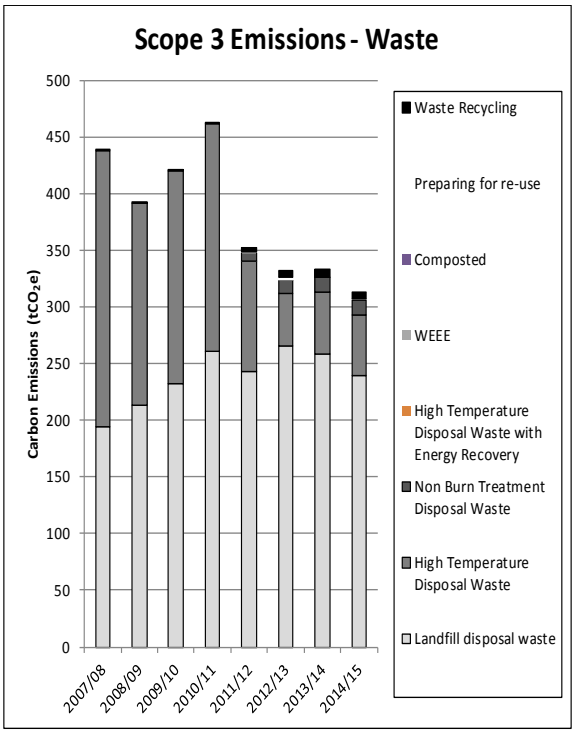
CO_2 Emissions (tCO_2e)		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Scope 2 - Indirect	Total	9,024	9,730	10,068	9,962	10,144	10,724	10,811	8,220
Electricity		9,024	9,730	10,068	9,962	10,144	10,724	10,811	8,220
Imported Heat/Steam		0	0	0	0	0	0	0	0

Scope 3 - Indirect

Please select which profile you would like to use for procurement: eClass

CO_2 Emissions (tCO_2e)		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Scope 3 - Indirect	Total	53,009	57,042	61,802	66,456	68,231	72,400	88,999	85,772
	Procurement (eClass)	38,854	42,205	45,929	49,538	49,760	52,653	66,215	61,858
	Travel	10,510	11,110	12,039	13,080	14,456	15,533	17,847	19,743
	Waste	439	392	420	462	353	332	333	314
	Water	196	198	187	185	210	203	248	252
	Energy Well to Tank and Transmissi	3,010	3,137	3,227	3,191	3,452	3,679	4,356	3,605





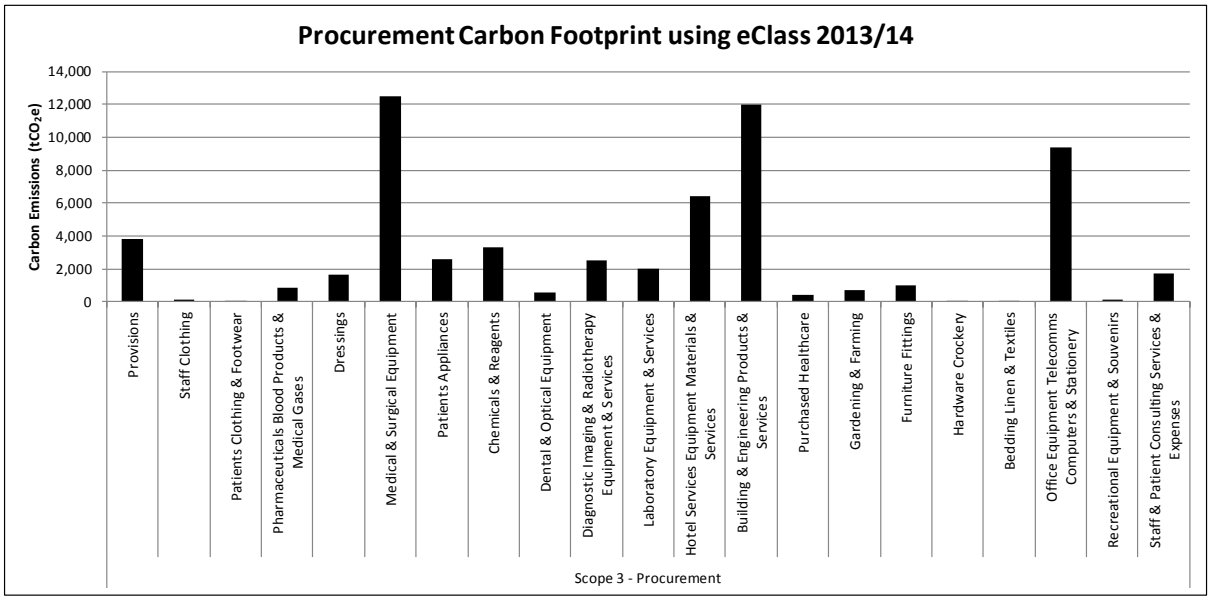
Scope 3 -Breakdown

CO_2 Emissions (tCO_2e)		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Scope 3 - Travel	Total	10,510	11,110	12,039	13,080	14,456	15,533	17,847	19,743
Business Travel estimate	Business and fleet estimate	10,510	11,110	12,039	13,080	14,456	15,533	17,847	19,743
Business Travel	Road	925	924	1,007	1,034	1,211	1,219	1,219	1,492
	Rail	0	0	0	0	0	0	0	0
	Air	0	0	0	0	0	0	0	0
Other Travel	Patient and Visitor	7,811	8,534	9,324	10,187	11,130	12,167	14,482	15,622
	Commute	1,774	1,653	1,708	1,860	2,116	2,147	2,146	2,629

CO_2 Emissions (tCO_2e)		2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Scope 3 - Water & Sanitation	Total	196	198	187	185	210	203	248	252
Water	Water Use	74	75	71	70	79	77	94	95
	Water Treatment	122	123	116	115	131	126	155	157

CO_2 Emissions (tCO_2e)	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	439	392	420	462	353	332	333	314
Waste Recycling	1	1	1	1	4	6	7	7
Preparing for re-use	0	0	0	0	0	1	0	0
Composted	0	0	0	0	0	0	0	0
WEEE	0	0	0	0	1	1	1	1
High Temperature Disposal Waste with Energy Recovery	0	0	0	0	0	0	0	0
High Temperature Disposal Waste	244	178	187	200	97	46	55	54
Non Burn Treatment Disposal Waste	0	0	0	0	7	12	13	13
Landfill disposal waste	194	213	232	261	243	266	259	240

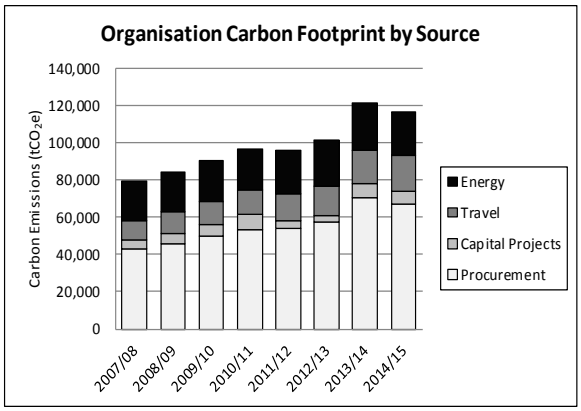
CO_2 Emissions (tCO_2e)	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Capital Spend	4,865	5,549	6,333	7,765	4,135	3,686	7,540	7,019

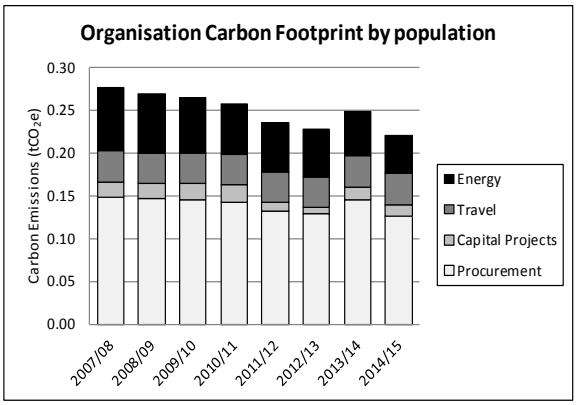


The above graph covers the year 2014/15

E-Class Procurement Profile									
CO_2 Emissions (tCO_2e) Profile	**Goods and Services**	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	Total	38,854	42,205	45,929	49,538	49,760	52,653	66,215	61,858
Scope 3 - Procurement	Provisions	2,678	2,909	3,165	3,414	3,753	3,881	7,326	3,844
	Staff Clothing	68	74	80	86	106	99	96	153
	Patients Clothing & Footwear	7	7	8	9	45	9	10	7
	Pharmaceuticals Blood Products &	640	695	756	816	757	540	1,512	835
	Dressings	226	245	267	288	470	1,242	1,416	1,664
	Medical & Surgical Equipment	13,412	14,569	15,854	17,100	13,732	13,122	12,718	12,485
	Patients Appliances	2,725	2,960	3,221	3,474	1,802	2,118	2,671	2,571
	Chemicals & Reagents	5,598	6,081	6,618	7,138	4,026	4,952	3,870	3,299
	Dental & Optical Equipment	78	84	92	99	123	448	504	556
	Diagnostic Imaging & Radiotherapy	2,065	2,243	2,441	2,633	652	1,428	1,189	2,520
	Laboratory Equipment & Services	707	768	836	902	833	2,324	967	2,003
	Hotel Services Equipment Material	523	568	618	667	3,971	3,651	5,141	6,387
	Building & Engineering Products &	3,835	4,165	4,533	4,889	11,679	8,764	19,478	12,021
	Purchased Healthcare	0	0	0	0	0	664	45	395
	Gardening & Farming	230	250	272	293	444	663	684	736
	Furniture Fittings	522	567	617	665	639	753	718	971
	Hardware Crockery	173	188	205	221	174	14	14	48
	Bedding Linen & Textiles	91	98	107	116	83	101	170	82
	Office Equipment Telecomms Com	4,303	4,675	5,087	5,487	5,119	6,543	6,083	9,400
	Recreational Equipment & Souveni	4	4	5	5	114	19	29	132
	Staff & Patient Consulting Services & Expenses	970	1,054	1,147	1,237	1,240	1,319	1,575	1,748

Appendix 5 -Carbon Emissions Benchmark Reports: 2014-2015



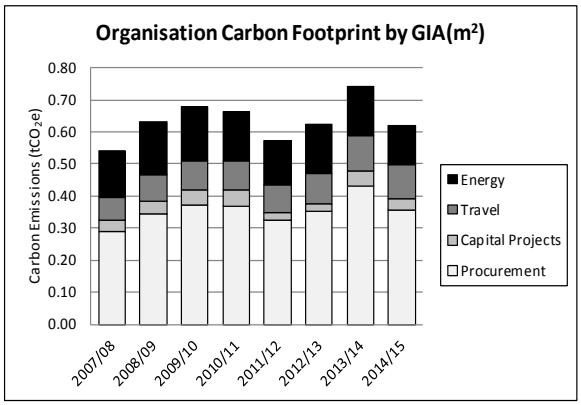


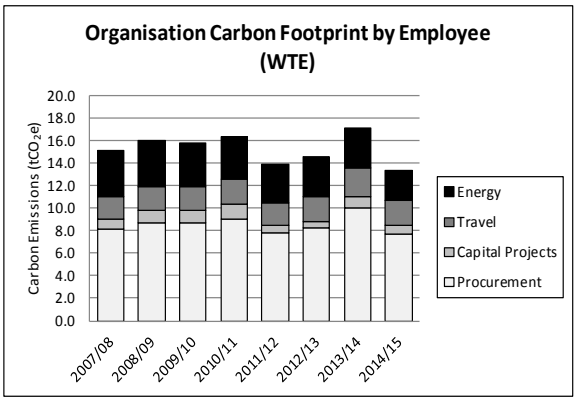
Carbon footprint (tCO2e)

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	79,617	84,515	90,855	96,697	96,101	101,746	121,628	116,745
Energy	21,450	21,812	22,553	22,299	23,424	24,987	25,492	23,185
Travel	10,510	11,110	12,039	13,080	14,456	15,533	17,847	19,743
Procurement	42,791	46,044	49,930	53,552	54,086	57,539	70,749	66,798
Capital Projects	4,865	5,549	6,333	7,765	4,135	3,686	7,540	7,019

Benchmarking by population (tCO_2e/person)

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	0.28	0.27	0.26	0.26	0.23	0.23	0.25	0.22
Energy	0.07	0.07	0.07	0.06	0.06	0.06	0.05	0.04
Travel	0.04	0.04	0.04	0.03	0.04	0.03	0.04	0.04
Procurement	0.15	0.15	0.15	0.14	0.13	0.13	0.14	0.13
Capital Projects	0.02	0.02	0.02	0.02	0.01	0.01	0.02	0.01



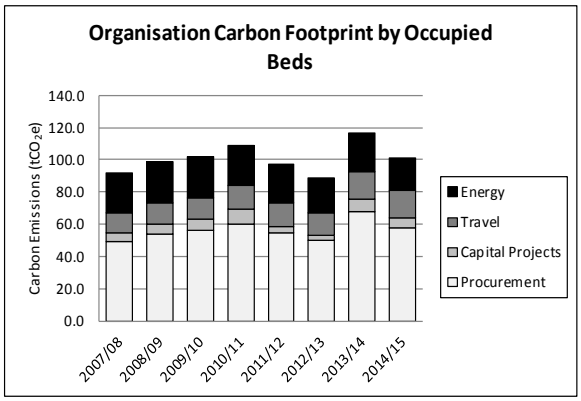


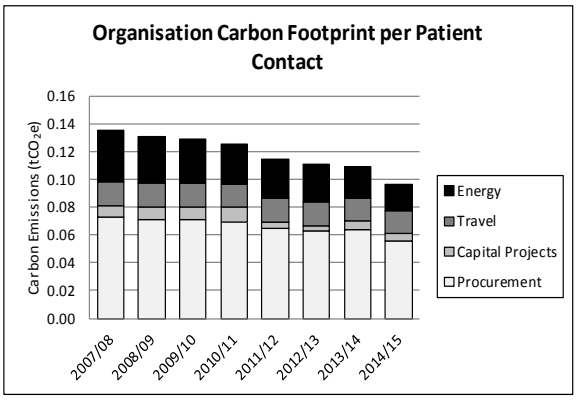
Benchmarking by Gross Internal Area (tCO_2e/m^2)

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	0.54	0.63	0.68	0.66	0.57	0.62	0.74	0.62
Energy	0.15	0.16	0.17	0.15	0.14	0.15	0.16	0.12
Travel	0.07	0.08	0.09	0.09	0.09	0.09	0.11	0.10
Procurement	0.29	0.34	0.37	0.37	0.32	0.35	0.43	0.35
Capital Projects	0.03	0.04	0.05	0.05	0.02	0.02	0.05	0.04

Benchmarking by Number of Staff (tCO_2e/WTE)

	2007/08	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	15.1	16.0	15.8	16.4	13.9	14.6	17.2	13.4
Energy	4.1	4.1	3.9	3.8	3.4	3.6	3.6	2.7
Travel	2.0	2.1	2.1	2.2	2.1	2.2	2.5	2.3
Procurement	8.1	8.7	8.7	9.1	7.8	8.3	10.0	7.6
Capital Projects	0.9	1.1	1.1	1.3	0.6	0.5	1.1	0.8





Benchmarking by Number of occupied beds (tCO_2e/bed)

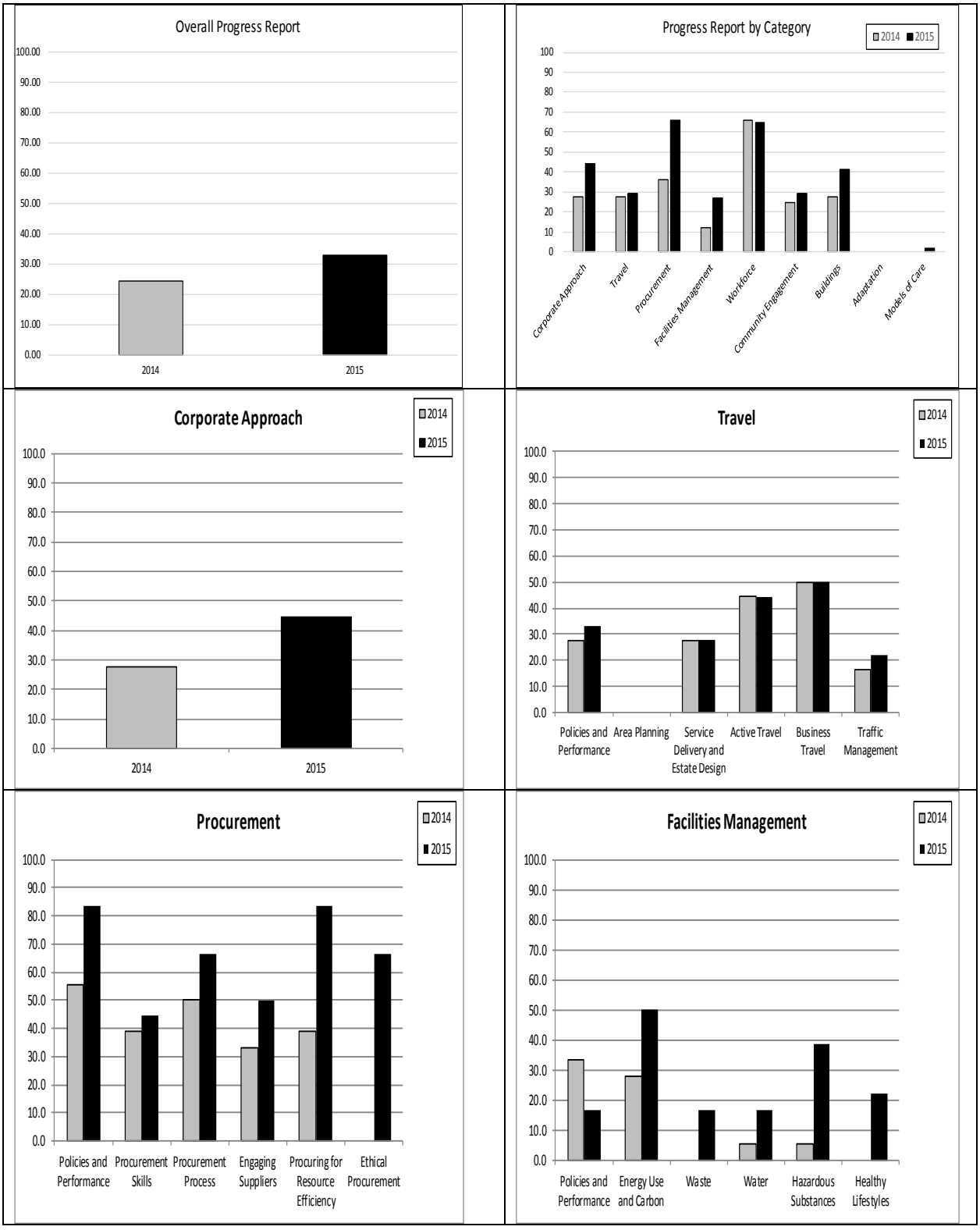
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	91.6	98.8	101.7	109.1	97.1	88.9	116.9	101.4
Energy	24.7	25.5	25.3	25.2	23.7	21.8	24.5	20.1
Travel	12.1	13.0	13.5	14.8	14.6	13.6	17.2	17.2
Procurement	49.2	53.9	55.9	60.4	54.6	50.3	68.0	58.0
Capital Projects	5.6	6.5	7.1	8.8	4.2	3.2	7.2	6.1

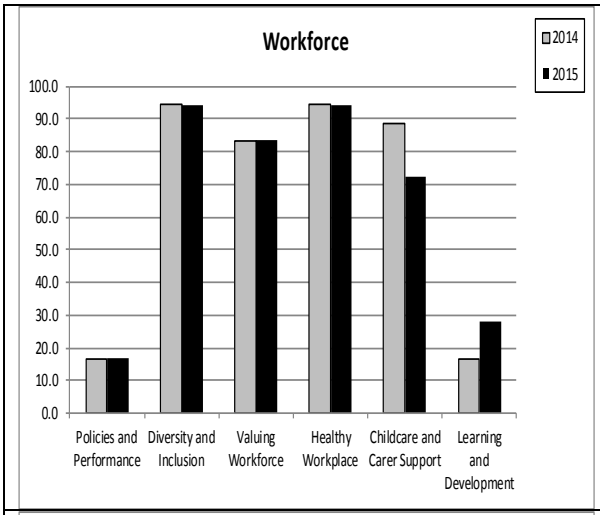
Benchmarking by Total Patient Contacts (tCO2e/patient contact)

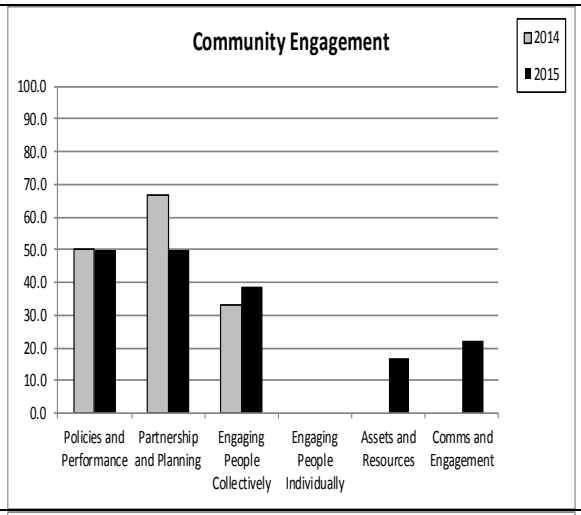
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total	0.14	0.13	0.13	0.13	0.11	0.11	0.11	0.10
Energy	0.04	0.03	0.03	0.03	0.03	0.03	0.02	0.02
Travel	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02
Procurement	0.07	0.07	0.07	0.07	0.06	0.06	0.06	0.06
Capital Projects	0.01	0.01	0.01	0.01	0.00	0.00	0.01	0.01

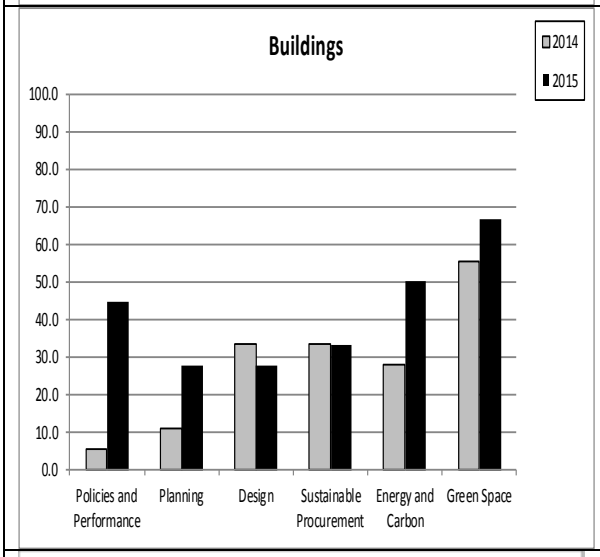
Appendix 6 Good Corporate Citizenship Assessment Reporting

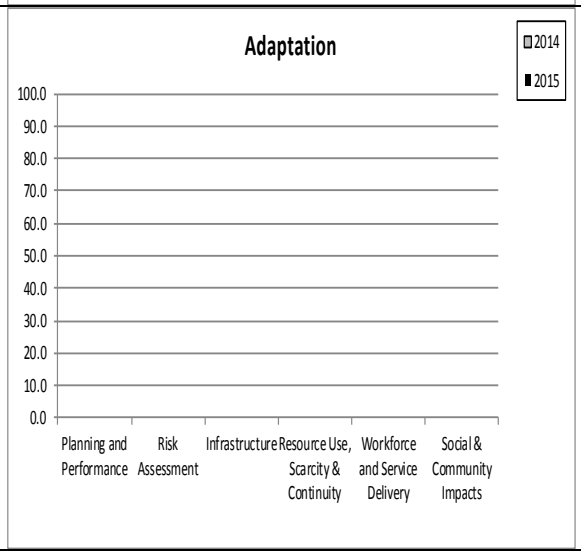
The following graphs show the Trusts performance in the Good Corporate Citizenship Assessment as compared with last year's performance.

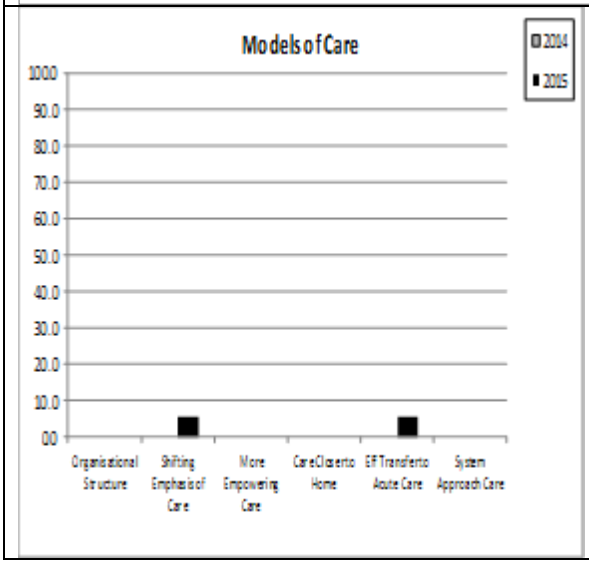



Workforce
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Diversity and Inclusion
Valuing Workforce
Healthy Workplace
Childcare and Carer Support
Learning and Development


Community Engagement
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Partnership and Planning
Engaging People Collectively
Engaging People Individually
Assets and Resources
Comms and Engagement


Buildings
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Policies and Performance
Planning
Design
Sustainable Procurement
Energy and Carbon
Green Space


Adaptation
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Planning and Performance
Risk Assessment
Infrastructure
Resource Use, Scarcity & Continuity
Workforce and Service Delivery
Social & Community Impacts


Models of Care
2014
2015
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Organisational Structure
Shifting Emphasis of Care
More Empowering Care
Care Closer to Home
ER Transfer to Acute Care
System Approach Care

Blank page

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors - 27 January 2016

Update on Progress to Transfer Whitby Community Services to Humber Foundation Trust

Action requested/recommendation

The Board of Directors is asked to note this report detailing progress against the transfer of Whitby community services to Humber Foundation Trust. The Board of Directors is also asked to consider any potential communications that need to be considered as a result of this transfer.

Summary

This paper describes the progress in relation to the due diligence work related to the transfer of the Whitby Community contract to Humber Foundation Trust.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☐

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Board of Directors
Risk	Risks are detailed in the report.
Resource implications	Resources implication detailed in the report.
Owner	Wendy Scott, Director of Out of Hospital Care
Author	Lynda Provins, Governor & Membership Manager
Date of paper	January 2016
Version number	Version 1

Board of Directors - 27 January 2016

Update on Progress to Transfer Whitby Community Services to Humber Foundation Trust

1. Introduction and background

This paper describes the progress in relation to the due diligence work related to the transfer of the Whitby Community contract to Humber Foundation Trust.

Following discussions with Hambleton, Richmondshire and Whitby CCG (HRW) in 2013/14, it was mutually agreed that HRW would seek another provider for Whitby community services (including Whitby Community Hospital). Notice was served on the Trust by HRW and following a tender exercise, Virgin Healthcare was announced as the preferred bidder. Subsequently, Virgin Healthcare pulled out of the transaction in October 2015 and HRW announced that Humber Foundation Trust (HFT) would take over as provider.

The ownership of Whitby Hospital transferred from the Trust to NHS Property Company in December 2015.

2. Update on progress

The Trust has been working closely with HRW and HFT to progress the due diligence exercise, which is nearly completed. HFT signed the contract with HRW on the 4th December 2015 and the date set for handover of services from the Trust to HFT is the 1st March 2016.

An overarching Service Level Agreement (SLA) and Business Transfer Agreement (BTA) has been drafted by the Trust in conjunction with Capsticks Solicitors and discussions about fine tuning these documents are on-going with HFT. The SLA will have a number of appendices describing the individual service specifications and associated price. This is being co-ordinated by the Trust Finance Department to ensure clarity, accuracy and consistency.

Discussions are currently on-going with HFT around the provision of Pharmacy and short term cover for some IT provision by the Trust. HFT have also indicated that they wish to continue with the provision of community specialist nursing services, Radiology, Pathology and Transport arrangements. The Trust is also negotiating around the continued use of outpatient facilities at Whitby Hospital. At a meeting held on the 6th January 2016, HFT also indicated that they are potentially interested in taking on Speech and Language Therapy Services and Dietetics, which may need to transfer later than the 1st March 2016.

The handover of services is dependent on the BTA and SLA being finalised and signed before 1st March 2016 and every effort is being made to achieve this, although it should be noted that HFT is due a Care Quality Commission inspection in early April so they are reporting competing priorities.

There is a number of staff who will transfer from the Trust to HFT and a formal TUPE consultation with staff was commenced on the 9th December 2015.

3. Conclusion	
The Trust is currently on track to finalise and sign the BTA and SLA by the scheduled date of 1st March 2016 when the handover of services is due to take place.	
4. Recommendation	
The Board of Directors is asked to note this report detailing progress against the transfer of community services to Humber FT and discuss any potential communications that need to be undertaken.	
Author	**Lynda Provins, Governor and Membership Manager**
Owner	**Wendy Scott, Director of Out of Hospital Care**
Date	**January 2016**

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Revision of Powers and Scheme of Delegation, Standing Orders and Standing Financial Instructions

Action requested/recommendation

The Board of Directors is asked to consider and approve the revised documents – Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation.

Summary

The Audit Committee reviewed the document at the November meeting and agreed to recommend approval of the documents by the Board of Directors.

The Audit Committee asked for the key changes to be highlighted to the Board.

Standing Orders – only two minor changes were made to the document.

1 Under section 2.1 Composition of the Board, the Standing Orders listed 'two other Executive Directors'. To bring it in line with the Constitution this has been altered to three other Executive Directors.
2 Under section 5 Committees, the Environment and Estates Committee has been included in the list of Board Committees.

No other changes were made to the Standing Orders.

Standing Financial Instructions – Minor editing changes were made to the document to ensure that it was in line with the revised Reservations of Powers and Scheme of Delegation references. Of note is the inclusion of the following:

1 At section 2.1 Audit Committee, the document now includes reference to the approval of audit services by External Audit and overseeing Clinical Audit. Both are duties of the Audit Committee as per the Audit Code.
2 At section 5.4 Investments, a change has been made that the Audit Committee is responsible for approving the Treasury Management Policy, rather than the Board of Directors.
3 At section 8.1.2, further clarity has been given to the approval responsibilities of the Remuneration Committee

Reservation of Powers and Scheme of Delegation – The document was reviewed in detail. The format of the document has been changed to make it easier to understand and read. The key changes in the document are:

1 In the Reservations of Powers section, the purpose and scope of the document has been revised to ensure that it takes into account some clear rules about the reservation of powers.
2 The scheme of matters reserved for the Board have been reviewed and updated, those for the Council of Governors have been reviewed, but no changes have been made.
3 The layout of the main Scheme of Delegation document has been changed.
4 The level of financial authority of the Chief Executive has been considered, but no change has been made. Some other authority levels have been brought in line with procurement legislation.
5 Past versions of the Reservation of Powers and Scheme of Delegation have allowed one authority level for capital and revenue business cases. As part of the development of the new business case system, these authorities have been split. This provides more clarity around the expenditure on a business case.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☒

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

This report is for noting only and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

This paper supports the overall principles of good governance as laid out in the Well-Led Framework and the Code of Governance

Progress of report	Corporate Directors Audit Committee
Risk	Associated risks have been assessed and identified.
Resource implications	There are no resource implications

Owner	Board of Directors
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	January 2016

York Teaching Hospital NHS
NHS Foundation Trust

Standing Orders

(For the regulation of proceedings and business of the Board of Directors)

Author:	**Foundation Trust Secretary**
Owner:	**Chief Executive**
Publisher:	**Foundation Trust Secretary**
Date of Issue:	**January 16**
Version:	**12**
Approved By:	**Trust Board**
Review date:	**December 16 (annually, along with SFIs and Scheme of Delegation)**

Foreword

Within the Licence issued by Monitor, the Sector Regulator, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the National Health Service Act 2006 amended by Health and Social Care Act 2012.

Standing Orders (SOs) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. These schedules are incorporated within the Trust's *Scheme of Delegation.*

These documents, together with Standing Financial Instructions, Standards of Business Conduct, Budgetary Control Procedures, the Fraud and Corruption Policy and the procedures for the Declaration of Interest provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation, Standing Financial Instructions and Budgetary Control Procedures provide a comprehensive business framework that can be applied to all activities, including those of the charitable Foundation. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents.

Contents

Introduction

Statutory Framework

York Teaching Hospitals NHS Foundation Trust (the Trust) is a Public Benefit Corporation, which came into existence on 1 April 2007 pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act") now superseded by the National Health Service Act 2006 (“the 2006 Act”) and amended by Health and Social Care Act 2012.

The principal place of business of the Trust is:

York Hospital
Wigginton Road
YORK
YO31 8HE

For administrative purposes, York Hospital is the Trust Headquarters

NHS Foundation Trusts are governed by the National Health Service Act 2006 amended by the Health and Social Care Act 2012

The functions of the Trust are conferred by this legislation and the Licence.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has statutory powers under Chapter 5 of the National Health Service Act 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

The business of the Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Trust, subject to any exception in the National Health Service Act 2006 amended by the Health and Social Care Act 2012 or the Trust’s Constitution. In accordance with the National Health Service Act 2006 amended by the Health and Social Care Act 2012, the following are set out in detail in the constitution:

- The composition of the Board of Directors
- Appointment, removal and terms of office of the Chairman, other Non-executive Directors and the Chief Executive
- Eligibility and disqualification of Directors and Governors
- Meetings of the board of directors
- Conflicts of interest of the directors
- Registers

- Public Documents
- Expenses

These Standing Orders add clarity and detail where appropriate. Nothing in these Standing Orders shall override the Trust's constitution and the 2006 Act amended by 2012 Act.

.

The Regulatory Framework requires the Board of Directors of the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust's Standing Orders and wider governance arrangements are further supported by various policies and procedures and for financial matters, by the Standing Financial Instructions and associated finance procedures. Certain powers are reserved to be exercised by the Board only, and these are covered by the Reservation of Powers and Scheme of Delegation for the Board. All other matters are delegated via the Chief Executive and Executive Directors to other Directors or Officers throughout the Trust, in accordance with the detailed Scheme of Delegation.

NHS Framework

The Code of Accountability requires that, inter alia, Boards of Directors draw up a schedule of decisions reserved to that Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated appropriately.

The constitution requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

Monitor's Code of Governance requires that Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to staff. The Schedule of Decisions reserved to the Board and the Scheme of Delegation form part of the Standing Orders. Audit and Remuneration Committees with formally agreed terms of reference are established under the constitution.

The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS subject for example to the Freedom of Information Act 2000.

1. Interpretation

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive).

Any expression to which a meaning is given in the National Health Service Act 2006 amended by the Health and Social Care Act 2012 or in the Financial or other Regulations made under the Acts or in the Authorisation or constitution shall have the same meaning in this interpretation and in addition:

"the 2006 Act" means the National Health Service Act 2006 as may be amended or replaced from time to time;

"the 2012 Act" means the Health and Social Care Act 2012 which amends the 2006 Act and may be amended or replaced from time to time;

"Accountable Officer" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the 2006 Act, this shall be the Chief Executive.

"Board of Directors" means the Chair, non-executive directors and the executive directors appointed in accordance with the Trust's constitution.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chair" is the person appointed in accordance with the constitution to lead the Board of Directors and the Council of Governors The expressions "the Chair" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"Committee" means a committee appointed by the Board of Directors.

"Committee members" means a person formally appointed by the Board of Directors to sit on or to chair specific committees.

"Constitution" means the constitution of the Trust as approved from time to time by the Council of Governors.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

“Council of Governors” means the Council of Governors as constituted in accordance with the constitution.

“Corporate Director” means the group of Directors who form the Corporate Director team.

.

"Finance Director" means the Executive Director of Finance who is the chief finance officer of the Trust.

“**Foundation Trust Secretary”** means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and York Teaching Hospital NHS Foundation Trust

"Executive Director" means a director who is an officer of the Trust appointed in accordance with the constitution. For the purposes of this document, “director” shall not include an employee whose job title incorporates the word director but who has not been appointed in this manner.

"Funds held on Trust" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Chapter 5 of the National Health Service Act 2006. Such funds may or may not be charitable.

“Licence” means the NHS Provider Licence issued by Monitor the Sector Regulator

"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a director who is not an officer of the Trust and who has been appointed in accordance with the constitution or under the previous system. This includes the Chair of the Trust.

"Officer" means employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or non-executive director of the Trust

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

“SID” means the Senior Independent Director

"Trust" means York Teaching Hospitals NHS Foundation Trust.

"Vice-chair" means the non-executive director appointed by the Board of Directors in consultation with the Council of Governors to take on the duties of Chair if the Chair is absent for any reason.

2. The Board of Directors

All business shall be conducted in the name of the Trust.

The powers of the Trust established under statute shall be exercised by the Board of Directors except as otherwise provided for in Standing Order 4.

Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. .

The Board of Directors has resolved that certain powers and decisions may only be exercised or made by that Board in formal session. These powers and decisions are set out in the Scheme of Delegation.

2.1 Composition of the Trust

In accordance with the Trust's constitution, the composition of the Board of Directors shall be:

A Chairman

6 other non-executive directors (one of whom is the Vice Chair)

A minimum of 6 executive directors including:

- the Chief Executive (the Chief Officer)
- the Finance Director (the Finance Director)
- the Executive Medical Director (who shall be a registered medical or dental practitioner)
- the Chief Nurse(who shall be a registered nurse or midwife)
- three other Executive Directors.

2.2 Appointment of the Chair and Non-Executive Directors

The Chair and Non-executive Directors are appointed by the Council of Governors. Non-executive Directors (including the Chairman) are to be appointed by the Council of Governors using the procedure set out in the constitution.

2.3 Terms of Office of the Chair and Non-executive Directors

The Chair and the Non-executive Directors are to be appointed for a period of office in accordance with the constitution and Code of Governance. The terms and

conditions of the office are decided by the Council of Governors at a General Meeting.

2.4 Appointment of Vice Chair of the Board of Directors

For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Board of Directors will appoint in consultation with the Council of Governors a Non-executive Director to be Vice-Chair for such a period, not exceeding the remainder of their term as Non-executive Director of the Trust, as they may specify. 3.11 sets out the provision if the Chair and Vice-Chair are absent.

Any Non-executive Director so elected may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Board of Directors may thereupon appoint another n]Non-executive Director as Vice-Chair in accordance with paragraph 2.8.

The Board of Directors should appoint one of the independent Non-executive Directors to be the Senior Independent Director, in consultation with the Council of Governors. The Senior Independent Director should be available to Members and Governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Finance Director has failed to resolve or for which such contact is inappropriate. The Senior Independent Director cannot be the Vice Chairman

2.5 Powers of Vice Chair

Where the Chair of the Trust has ceased to hold office, or has been unable to perform duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include reference to the Vice Chair.

3. Meetings of the Board of Directors

Meetings of the Board of Directors are to be held in public. . Members of the public may be excluded from a meeting for special reasons as determined by the Chairman in discussion with the Foundation Trust Secretary.

The Foundation Trust Secretary on the instruction of the Chairman shall give such direction as seen fit in regard to arrangements for meetings to accommodate presenters of papers and information to the Board of Directors and will ensure that business will be conducted without interruption and without prejudice. The Chairman has the power to exclude visitors on grounds of the confidential nature of the business to be transacted.

3.1 Calling Meetings

3.2 Notice of Ordinary Meetings – The Foundation Trust Secretary shall give to all Board Members at least fourteen days written notice of the date and place of every meeting of the Board of Directors. The Chairman may exclude any member of the public

from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

3.3 **Notice of Extraordinary Meetings** – At the request of the Chairman or four Board Members, the Foundation Trust Secretary shall send a written notice to all Board Members as soon as possible after receipt of such a request. The Foundation Trust Secretary shall give to all Board Members at least fourteen days written notice of the date and place of every meeting of the Board of Director. If the Foundation Trust Secretary fails to call such a meeting, then the Chairman or four Board Members shall call such a meeting.

3.4 **Notice of Urgent Meetings**

At the request of the Chairman, the Foundation Trust Secretary shall send a written notice to all Board Members as soon as possible after receipt of such a request. The Foundation Trust Secretary shall give Board Members as much notice as is possible in light of the urgency of the request. If the Trust Secretary
fails to call such a meeting, then the Chairman or four Board Members shall call such a meeting.

Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign shall be delivered to every member of the Board, or sent electronically or by post to the agreed address of such director, so as to be available at least seven clear days before the meeting. A postal notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post. Save in the case of emergencies, for each meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the agenda, shall be available from the Trust and displayed on the Trust's website at least three clear days before the meeting. (Required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4)(a).)

Lack of service of the notice on any Director shall not affect the validity of a meeting.

Agendas will be sent to Board of Directors and the Council of Governors no less than seven days before the meeting.

3.5 Setting the Agenda

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting.

A director who requires an item to be included on the agenda should advise the Foundation Trust Secretary prior to the agenda being agreed with the Chairman and no less than ten days before a meeting.

3.6 Chair of Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair shall preside. If the Chair and Vice-Chair are absent such Non-executive Director as the directors present shall choose shall preside.

If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chair, if present, shall preside. If the Chairman and Vice-Chairman are absent, or are disqualified from participating, such Non-executive Director as the directors present shall choose shall preside.

3.7 Petition

Where a petition has been received by the Trust, the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting**.**

3.8 Annual General Meeting

The Trust will publicise and hold an Annual General Meeting.

3.9 Notices of Motion

A director desiring to move or amend a motion should advise the Foundation Trust Secretary prior to the agenda being agreed with the Chairman and no less than 10 days before a meeting. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.10 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.11 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within 6 months.

3.12 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business.
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put.

- A motion under Section 1 (2) of the Public Bodies (Admission to meetings) Act 1960 resolving to exclude the public (including the press).

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.13 Chair's Ruling

Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity, and any other matters shall be observed at the meeting.

3.14 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

If at least four of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.15 Minutes

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person Chairman of the meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

In line with the 2012 Act the minutes of the public meeting of the Board of Directors will be circulated to the Council of Governors in advance of the next Board of Directors meeting.

Minutes shall be circulated in accordance with directors' wishes.

3.16 Suspension of Standing Orders

Except where this would contravene any statutory provision or any provision of the Licence or of the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two executive directors and two non-executive directors, and that a majority of those present vote in favour of suspension.

A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

No formal business may be transacted while Standing Orders are suspended.

The Audit Committee shall review every decision to suspend Standing Orders.

3.17 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.12 has been given; and
- no fewer than half of the Trust's total Non-executive Directors in post vote in favour of amendment; and
- at least two-thirds of the directors are present; and
- the variation proposed does not contravene a statutory provision or provision of the Licence or of the Constitution

3.18 Record of Attendance

The names of the Chairman and directors present at the meeting shall be recorded in the minutes.

3.19 Quorum

No business shall be transacted at a meeting of the Board of Directors unless at least seven members of the whole number of the directors are present including at least two Executive Directors and two Non-executive Directors, one of whom is the Chairman or Vice Chairman and as such has a casting vote.

An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chairman or a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

4. Arrangements for the exercise of functions by delegation

Subject to a provision in the Licence or the Constitution, the Board of Directors may make arrangements for the exercise, on its behalf of any of its functions

- by a committee or sub-committee or group.
- appointed by virtue of SO 5.1 or 5.2 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.1 Emergency Powers

The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chairman after having consulted at least two Non-executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

4.2 Delegation to Committees

The Board of Directors shall agree, as and when it deems appropriate, to the delegation of executive powers to be exercised by committees, sub-committees or groups, which it has formally constituted. The constitution and terms of reference of these committees, sub-committees or groups, and their specific executive powers shall be approved by the Board of Directors.

4.3 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised

on its behalf by the Chief Executive. The Chief Executive shall determine which functions shall be delegated to officers to undertake.

The Chief Executive shall prepare a Scheme of Delegation (which is set out in the Standing Financial Instructions) identifying proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors or the Director of Finance or other Executive Director (this is because the Scheme of Delegation does not discharge accountability to NEDs to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.4 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors, Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. Committees

5.1 Appointment of Committees

Subject to the Licence and the Constitution and any direction given by Monitor, the Board of Directors may and, if directed by Monitor shall, appoint committees of the Trust, consisting wholly (or partly) of directors of the Trust. The Board of Directors may only delegate its powers to such a committee if that committee consists entirely of board directors.

A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the regulator, and in accordance with the Constitution, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they are directors of the Trust); or wholly of persons who are not directors of the Trust.

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the Board of Directors. In which case the term “Chairman” is to be read as a reference to the Chairman of the committee or sub-committee as the context

permits, and the term “director” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

Each such committee, sub-committee or group shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation [or direction issued by the regulator] Such terms of reference shall have effect as if incorporated into the Standing Orders.

The Board of Directors shall approve the appointments to each of the committees, sub-committees or group, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Licence and Constitution. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with its constitution.

The committees and sub-committees established by the Trust are:

- Audit Committee
- Remuneration Committee
- Quality and Safety Committee
- Finance and Performance Committee
- Workforce Strategy Committee
- Corporate Risk Committee
- Estates and Environment Committee

Such other committees may be established, as required, to discharge the Board's responsibilities.

5.2 Confidentiality

A member of a committee, sub-committee or group shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

A director of the Trust or a member of a committee or sub-committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee or sub-committee, notwithstanding that the matter has been reported or action has been concluded, if that Board or committee shall resolve that it is confidential.

6. Declarations of Interest

The Constitution requires members of the Board of Directors to declare interests, which are relevant and material to the Board of Directors. All existing directors should

declare such interests. Any directors appointed subsequently should do so on appointment.

Interests, which should be regarded as “relevant and material”, are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

The register of directors' interests will include as appropriate all interests of directors and their close family members where they have control, joint control or a significant influence, regardless of whether this is in relation to healthcare

If Board Members have any doubt about the relevance of an interest, advice should be sought from the Foundation Trust Secretary, who has a duty to report and discuss such matters with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

A register of directors’ interests will be maintained and held by the Foundation Trust Secretary and presented monthly to the Board of Directors. This will be formally recorded in the minutes. Any changes in interests should be officially declared to the Foundation Trust Secretary where an appropriate amendment will be made and the updated register presented at the next Board of Directors meeting following the change occurring.

Directors' directorships of companies in 6.2.a above likely or possibly seeking to do business with the NHS (6.2.b above) should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

During the course of a Board of Directors meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes

voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

7. Disability of Chairman and Directors in procedures on account of pecuniary interest

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The Board of Directors may exclude the Chairman or a director of that Board from a meeting of that Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chairman or a Non-executive Director in accordance with the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chairman or a director shall be treated, subject to SO 7.2 and SO 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chairman or a director shall not be treated as having a pecuniary interest in any, proposed contract or other matter by reason only:

(a) of membership of a company or other body, if there is no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or

discussion of or in voting on, any question with respect to that contract or matter.

Where the Chairman or a director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class.

This Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a committee or sub-committee as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he/she is also a director of the Trust) as it applies to a director.

8. Standards of Business Conduct

8.1 Policy

Staff must comply with the national guidance contained in HSG(93)5 “Standards of Business Conduct for NHS staff” and contained in the Trust policy Standards of Business Conduct. Reference must be made to the Standards of Business Conduct policy for further guidance.

9. In-House Services

In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a purchasing officer and a Director of Finance representative. For services having a likely annual

expenditure exceeding £500,000, a Non- executive Director should be a member of the evaluation team.

All groups should work independently of each other and individual officers may be a director of more than one group but no director of the in-house tender group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Board of Directors.

The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

10. Custody of Seal and Sealing of Documents

10.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Foundation Trust Secretary in a secure place,

10.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or a committee thereof or where the Board of Directors has delegated its powers. The affixing of the Seal shall be attested and signed by the Chairman (or in his/her absence a Non-executive Director) and the Chief Executive (or in his/her absence his/her deputy).

Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate).

10.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Audit Committee annually. (The report shall contain details of the seal number, the description of the document and date of sealing and the value of the contract). The book will be held by the Foundation Trust Secretary.

11. Signature of documents

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document

(not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which that Board has delegated appropriate authority.

12. Miscellaneous

12.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

12.2 Documents having the standing of Standing Orders

Standing Financial Instructions and the Reservation of Powers and Scheme of Delegation shall have effect as if incorporated into Standing Orders.

12.3 Review of Standing Orders

Standing Orders, and all documents having effect as if incorporated in Standing Orders, shall be reviewed annually by the Audit Committee on behalf of the Board of Directors.

York Teaching Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Author:	**Head of Corporate Finance**
Owner:	**Andrew Bertram, Finance Director**
Publisher:	**Andrew Bertram, Finance Director**
Date of Issue:	**January 2016**
Version:	**9**
Approved By:	**Board of Directors**
Review date:	**December 2016 (annually, along with Standing Orders and Reservation of Powers and Scheme of Delegation)**

CONTENTS

1. INTRODUCTION

1.1 General

1.1.1 The Code of Accountability requires that each NHS Foundation Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors and the Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Finance Director.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Finance Director **must be sought before acting**. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 **FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

1.1.6 Overriding Standing Financial Instructions - if for any reason these Standing Financial Instructions are not complied with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Finance Director as soon as possible.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the Health and Social Care (Community Health and Standards) Act 2003 and other Acts relating to the National Health Service or in the Financial or other Regulations made under the Acts or in the Authorisation or Constitution shall have the same meaning in this interpretation and in addition:

"**Accountable Officer**" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. In accordance with the Act, this shall be the Chief Executive.

"**Authorisation" means the authorisation of the Trust by Monitor, the Independent Regulator of NHS Foundation Trusts**

"**Board of Directors**" means the Chair, non-executive directors and the executive directors appointed in accordance with the Trust's Constitution.

"**Budget**" means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"**Budget Holder**" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"**Chair**" is the person appointed in accordance with the Constitution to lead the Board of Directors and the Council of Governors. The expression "the Chair" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"**Chief Executive**" means the chief officer of the Trust.

"**Commissioning**" means the process for determining the need for and for obtaining the supply of healthcare and related services from the Trust

"**Committee**" means a committee appointed by the Board of Directors.

"**Committee Member**" means a person formally appointed by the Board of Directors to sit on or to chair specific committees.

"**Constitution**" means the constitution of the Trust as approved from time to time by the Council of Governors.

"**Contracting and Procuring**" means the system for obtaining the supply of goods, materials, manufactured items, services, building and

engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"**Executive Director**" means a director who is an officer of the Trust appointed in accordance with the Constitution. For the purposes of this document, "Director" shall not include an employee whose job title incorporates the word Director but who has not been appointed in this manner.

"**Finance Director**" means the chief finance officer of the Trust.

"**Funds Held on Trust**" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the National Health Services Act 2006. Such funds may or may not be charitable.

"**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice.

"**Monitor**" means the Independent Regulator of NHS Foundation Trusts.

"**Nominated Officer**" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"**Non-Executive Director**" means a director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chair of the Trust.

"**Officer**" means employee of the Trust or any other person who exercises functions for the purposes of the Trust other than solely as a Staff Governor or Non-executive Director of the Trust.

"**Provider Licence**" means the licence issued by Monitor.

"**Secretary of State Directions**" means the Directions to NHS Bodies on Counter Fraud Measure issued in 1999, and subsequently revised in 2004. Each NHS body is required to take necessary steps to counter fraud in the NHS in accordance with these Directions and the Chief Executive and Finance Director are mandated to monitor and ensure compliance with these Directions

"**SFIs**" means Standing Financial Instructions.

"**SOs**" means Standing Orders.

"**Trust**" means York Hospitals NHS Foundation Trust.

"**Vice-Chair**" means the non-executive director appointed by the Council of Governors to take on the duties of Chair if the Chair is absent for any reason.

1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 Responsibilities and Delegation

1.3.1 The Board of Directors exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Reservation of Powers and Scheme of Delegation document.

1.3.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Reservation of Powers and Scheme of Delegation document.

1.3.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Reservations of Powers and Scheme of Delegation document adopted by the Trust.

1.3.4 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accountable Officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive and Finance Director will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.3.6 It is a duty of the Chief Executive to ensure that existing members of the Board of Directors and employees and all new appointees are notified of, and understand, their responsibilities within these Instructions.

1.3.7 The Finance Director is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Finance Director include:

(d) the provision of financial advice to other members of the Board of Directors and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.10 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Finance Director.

2 AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing Clinical Audit, Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board of Directors;

(f) approval of non-audit services by External Audit.

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors. Exceptionally, the matter may need to be referred Monitor.

2.1.3 It is the responsibility of the Finance Director to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal audit services.

2.2 Finance Director

2.2.1 The Finance Director is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current controls assurance guidance, including for example compliance with control criteria and standards,

(ii) major internal financial control weaknesses discovered,

(iii) progress on the implementation of internal audit recommendations,

(iv) progress against plan over the previous year,

(v) strategic audit plan covering the coming three years,

(iv) a detailed plan for the coming year.

2.2.2 The Finance Director and designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board of Directors or employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,

(ii) waste, extravagance, inefficient administration,

(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the controls assurance statements in accordance with relevant guidance.

2.3.2 Whenever a matter arises that involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Finance Director. The reporting system for internal audit shall be agreed between the Finance Director, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.3.5 The reporting process agreed is that the Internal Audit department will issue a formal written audit report to the appropriate Directors of Clinical and Functional Directorates at the conclusion of each piece of audit work, within an appropriate timescale. Outstanding audit reports will be reviewed by the Finance Director who will initiate immediate remedial action.

2.3.6 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the timescales specified in the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Changes implemented must be maintained in the future and not viewed as merely satisfying an immediate audit point.

2.3.7 A summary of reports and an annual report will be presented to the Audit Committee.

2.3.8 The Head of Internal Audit has the right to report directly to the Chief Executive of the Board of Directors if, in his/her opinion, the circumstances warrant this course of action.

2.4 Fraud and Corruption

2.4.1 In line with their responsibilities, the Trust Chief Executive and Finance Director shall monitor and ensure compliance with NHS Protect Directions on fraud and corruption.

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.4.3 The Local Counter Fraud Specialist shall report to the Trust Finance Director and shall work with staff in the NHS Counter Fraud Services and the Counter Fraud Operational Service in accordance with the Department of Health Fraud and Corruption Manual.

2.5 External Audit

2.5.1 The external auditor is appointed by the Council of Governors from an approved list recommended by the Audit Committee and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. Should there appear to be a problem then this should be raised with the external auditor and referred on to the Council of Governors. If the issue cannot be resolved by the Council of Governors it should be reported to Monitor.

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account Foundation Trust financial requirements, including compliance with forecast income and expenditure plans and cash resources. The annual business plan will contain:

(a) a statement of the significant assumptions and risks on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Finance Director will, on behalf of the Chief Executive, ensure annual budgets are prepared. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan as submitted to Monitor;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

3.1.3 The Finance Director shall monitor financial performance against budget and business plan, periodically review them, and report to the Board of Directors.

3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets to be compiled and monitoring reports to be prepared.

3.1.5 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully in accordance with the Budget section of the Trust Finance Manual.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be

in writing, reflecting the Scheme of Delegation, and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service; and

(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total set by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 Budgetary Control and Reporting

3.3.1 The Finance Director will devise and maintain systems of budgetary control. These will include:

(a) regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation;

(vii) an updated assessment of financial risk;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no employees are appointed without the approval of the Chief Executive via the Vacancy Control process.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements, cost reductions and efficiencies and income generation initiatives in accordance with the requirements of the Annual Business Plan.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 10.)

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation e.g. Monitor.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Finance Director, on behalf of the Trust, will prepare financial returns and reports in accordance with the accounting policies and guidance laid down within International Financial Reporting Standards, as modified by the guidance given by Monitor with the approval of HM Treasury.

4.2 The Trust's annual accounts must be audited by the external auditor appointed by the Council of Governors. The Trust's audited annual accounts must be approved by the Board of Directors and presented to a public meeting of the Council of Governors and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with Monitor's FT Annual Reporting Manual (FT ARM).

5 BANK ACCOUNTS, INVESTMENT AND EXTERNAL BORROWING

5.1 General

5.1.1 The Finance Director is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account Monitor's guidance/directions.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank Accounts

5.2.1 The Finance Director is responsible for:

(a) the operation of bank accounts;

(b) establishing separate bank accounts for the Foundation Trust's non-exchequer/charitable funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board of Directors all instances where bank accounts may become or have become overdrawn, together with the remedial action taken.

5.3 Banking and Investment Procedures

5.3.1 The Finance Director will prepare detailed instructions on the operation of bank accounts that must include:

(a) the conditions under which the bank accounts are to be operated;

(b) the limit to be applied to any overdraft; and

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Finance Director must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Investments

5.4.1 The Finance Director will comply with the Treasury Management Policy, as approved by the Audit Committee, when borrowing and investing surplus funds.

5.5 External Borrowing

5.5.1 The Finance Director will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both Public Dividend Capital and any proposed new borrowings.

5.5.2 Any application for a loan or overdraft will only be made by the Finance Director or by an employee so delegated by him/her.

5.5.3 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

5.5.4 All long term borrowings must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

5.6 Tendering and Review

5.6.1 The Finance Director will review the commercial bank arrangements of the Foundation Trust at regular intervals to ensure that they reflect best practice and represent best value for money.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Finance Director is also responsible for the prompt invoicing and banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow the Monitor's guidance when entering into contracts for patient services.

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed.

6.2.3 The Finance Director shall determine the appropriate charges or fees for the provision of all services provided to other organisations and individuals.

6.2.4 It is the responsibility of all employees to inform the Finance Director promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 All staff have an overriding responsibility to collect fees due for the provision of chargeable services thus ensuring the minimisation of debts.

6.3.2 The Finance Director is responsible for the appropriate recovery action on all outstanding debts.

6.3.3 Income not received should be dealt with in accordance with losses procedures. (See section 12.)

6.3.4 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked promptly and intact. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Finance Director and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this process should follow guidance provided by NHS Protect (previously known as the NHS Counter Fraud and Security Management Service). Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Special Payments procedures.

7 NHS SERVICE CONTRACTS FOR PROVISION OF SERVICES

7.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable legally binding service contracts with service commissioners for the provision of NHS services.

7.2 All service contracts should aim to implement the agreed priorities contained within the Integrated Business Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the Provider Licence from Monitor
- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information based on national and local tariffs, and underlying reference costs
- the National Institute for Health and Care Excellence Guidance
- the National Standard Local Action – Health and Social Care Standards and Planning Framework
- that service contracts build where appropriate on existing partnership arrangements;
- that service contracts are based on integrated care pathways.

7.3 A good service contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The service contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

7.4 The Chief Executive, as the accountable officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the service contract. This will include information on costing arrangements.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

8.1 Remuneration and Terms of Service

8.1.1 In accordance with Standing Orders the Board of Directors shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Remuneration Committee will:

(a) determine the appropriate remuneration and terms of service for the Chief Executive, and Corporate Directors employed by the Trust including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars; and

(iii) arrangements for termination of employment and other contractual terms

(b) determine the terms of service for the Chief Executive, and Corporate Directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking accounts of such national guidance as is appropriate.

8.1.3 The Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.4 The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board of Directors and said allowances will be approved by the Council of Governors.

8.2 Funded Establishment

8.2.1 The workforce plans of the Trust will be reconciled with the funded establishments on expenditure budgets, to ensure affordability of appropriate staffing levels.

8.2.2 The funded establishment of any department may not be varied recurrently without the approval of the Chief Executive, on the advice of the Director of Workforce and Organisational Development.

8.3 Staff Appointments

8.3.1 No officer may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of his approved budget and funded establishment.

(c) The hire of agency staff and locums must comply with the guidelines laid out in the Reservation of Powers and Scheme of Delegation

8.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

8.4 Processing Payroll

8.4.1 The Finance Director is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances (in conjunction with the Director of Workforce and Organisational Development);

(c) making payment on agreed dates; and

(d) agreeing method of payment.

8.4.2 The Finance Director will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records; and

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) Submitting a signed copy of the notification of starter/variation in contract forms and other such documentation as may be required immediately upon an employee commencing duty;

(b) submitting time records and other notifications in accordance with agreed timetables;

(c) completing time records and other notifications in accordance with the Finance Director's instructions and in the form prescribed by the Finance Director; and

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Finance Director must be informed immediately.

(e) taking responsibility for managing staff costs within the available resources and engaging staff in accordance with Trust policies and procedures.

8.4.4 Regardless of the arrangements for providing the payroll service, the Finance Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of Employment

8.5.1 The Board of Directors shall delegate responsibility to managers

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Director of Workforce and Organisational Development and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

9 NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 As part of the approval of annual budgets, the Board of Directors will approve the level of non-pay expenditure and the Chief Executive will determine the level of delegation to budget managers as part of the Reservation of Powers and Scheme of Delegation.

9.1.2 The Chief Executive, as the accountable officer, will determine:

(a) prime budget holders who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level (See Reservation of Powers and Scheme of Delegation document)

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.1.4 The Chief Executive will determine the level of delegation in respect of entering into contracts (refer to Reservation of Powers and Scheme of Delegation for delegated limits).

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Estates or Purchasing department shall be sought. Where this advice is not acceptable to the requisitioner, the Finance Director (and/or the Chief Executive) shall be consulted.

9.2.2 The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3 The Finance Director will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; current thresholds are set out in 9.5 below;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board Directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts (where providing good value for money) or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);

(b) the appropriate Corporate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Finance Director;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

(a) all contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU regulations on public procurement (thresholds and regulations together with the consequences of breaching these regulations are attached at Appendix 1).

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health/Monitor. For 2015-16 Monitor determined the threshold for this to be £50,000.

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

Refer to the national guidance contained in "Standards of Business Conduct for NHS Staff"

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except purchases from petty cash or on purchase cards;

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Finance Director;

9.3 Petty Cash

9.3.1 Purchases that will be reimbursed from petty cash are restricted in value and by type, in accordance with instructions issued by the Finance Director.

9.3.2 All reimbursements must be supported by receipt(s) and certified by an authorised signatory.

9.3.3 Petty cash records are maintained in a form as determined by the Finance Director.

9.4 Building and Engineering Transactions

9.4.1 The Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE, and Procure 21+ guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

9.5 Tendering Quotation and Contract Procedure

9.5.1 The Trust shall ensure the competitive tenders are invited for the supply of goods, materials, manufactured articles and services, for the design, construction and maintenance of buildings and engineering works and for disposals.

9.5.2 Formal tendering procedures may be waived by officers for whom powers have been delegated by the Chief Executive through the Scheme of Delegation where one or more of the following applies:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (this figure is reviewed annually). It is a breach of the Regulations to spilt contracts to avoid the thresholds. The value used should be the overall contract value for the life of the equipment or service not annual costs;

(b) This is an extension to an existing (or very recently expired) contract which was sourced by competitive selection or via a framework either by the Trust or by agencies such as the Crown Commercial Service, NHS Supply Chain or another commercial procurement collaborative acting on behalf of a NHS organisation;

(c) Where the supply of the proposed goods or service is under special arrangements by any Government Agency (e.g. Procure21+ as it applies to construction contracts).

9.5.3 The negotiated procedure without the prior publication of a contract notice (the STA) may be used in the following circumstances but should not be used to avoid competition or for administrative convenience:

(a) There is an absence of suitable tenders. (i.e. The goods/services/works having been appropriately advertised using the open procedure or the restricted procedure);

(b) For reasons of extreme urgency brought about by events unforeseeable by, and not attributable to, the Trust, e.g. flood, fire or system failure. Failure to plan properly is not a justification for single tender;

(c) Specialist expertise / equipment is required and it is only available from one source. (i.e. for technical, artistic reasons or connected to the protection of exclusive rights).

(d) There is clear benefit to be gained from maintaining continuity where:

(i) the goods are a partial replacement for, or in addition to, existing goods or an installation; and

(ii) to obtain the goods from another supplier would oblige the Trust to acquire goods having different technical characteristics which may result in incompatibility and/or disproportionate technical difficulties in the operation or maintenance of the existing. This must be more than familiarity. This continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Where a responsible officer decides that competitive tendering is not applicable and should be waived by virtue of the above, details should be recorded on the Single Tender Approval Form and submitted to the Chief Executive for approval. Responsible officers must follow the single tender action guidance available from the Procurement Department. Details of these approvals will be reported to the Audit Committee.

9.5.4 All invitations to tender should be sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods, materials or undertake the service required.

9.5.5 The firms/individuals invited to tender (and where appropriate quote) should be as set out in the tendering procedures.

9.5.6 Quotations are required where the formal tendering procedures are waived under 9.5.2 above.

9.5.7 All quotations should be treated as confidential and should be retained for inspection.

9.5.8 The Chief Executive or his nominated officer should evaluate the quotations and select the one which gives best value for money. If this is not the lowest, then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

9.5.9 Where tenders or quotations are not required the Trust shall procure goods and services in accordance with procurement procedures approved by the Board of Directors.

9.5.10 The Chief Executive shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or in-house. The Board of Directors may also determine from time to time

that in-house services should be market tested by competitive tendering. (Standing Order 9)

9.5.11 The competitive tendering or quotation procedure shall not apply to the disposal of:

(a) Items with an estimated sale value of less than £15,000;

(b) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction;

(c) Obsolete or condemned articles and stores; which may be disposed of in accordance with the procurement policy of the Trust;

10 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

10.1 Capital Investment

10.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

10.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is produced, in line with the limits set out in the Reservation of Powers and Scheme of Delegation, setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

(ii) appropriate project management and control arrangements;

(iii) the involvement of appropriate Trust personnel and external agencies; and

(b) that the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

10.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issues procedures for their management, incorporating the recommendations of “CONCODE”.

The Finance Director shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

10.1.5 The Finance Director shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

10.1.6 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures will:

(a) be designed to ensure that each project stays within estimated/budgeted costs at each milestone;

(b) be issued to project managers and other employees/persons involved in capital projects;

(c) incorporate simple checklists designed to ensure that important requirements are complied with on each project.

10.2 Private Finance (including leasing)

10.2.1 The Trust may test for PFI when considering a major capital procurement.

10.2.2 When the Trust proposes to use finance the following procedures shall apply:

(a) The Finance Director shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors.

(c) Any finance or operating lease must be agreed and signed by the Finance Director.

10.3 Asset Registers

10.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets.

10.3.2 The Trust shall maintain an Asset Register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the guidance issued by Monitor.

10.3.3 Additions to the Fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

10.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

10.3.5 The Finance Director shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers.

10.3.6 The value of each asset shall be depreciated using methods and rates in accordance with Monitor's FT ARM.

10.4 Security of Assets

10.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

10.4.2 Asset control procedures, (including both purchased and donated assets) must be approved by the Finance Director. These procedures shall make provision for:

(a) recording of managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to assets recorded;

(f) identification and reporting all costs associated with the retention of an asset.

10.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Finance Director.

10.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS Foundation Trust property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

10.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and employees in accordance with the procedure for reporting losses.

10.4.6 Where practical, assets should be marked as Trust property.

10.4.7 Equipment and other assets may be loaned to or from the Trust. Employees and managers must ensure that the Trust's management procedure is followed, in particular conditions attaching to the loan are documented and the assets identified. Assets loaned to the Trust must not be entered in the Trust's asset register.

11 STORES AND RECEIPT OF GOODS

11.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

11.2 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Trust's Head of Procurement. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

11.3 A number of principles apply to the operation of all stores; managers of stores and stock are responsible for ensuring that:-

(a) stocks are kept to a minimum, commensurate with delivery and cost effective purchasing;

(b) delegation of responsibility must be clearly defined and recorded. The Finance Director may require access to the record in writing;

(c) the designated manager must be responsible for security arrangements; the custody of keys etc must be clearly defined in writing;

(d) security measures, including marking as Trust property, must be commensurate with the value and attractiveness of the stock;

(e) stocktaking arrangements are agreed with the Finance Director and a physical check undertaken at least once a year;

(f) the system of store control, including receipt and checking of delivery notes etc, is agreed with the Finance Director;

(g) there is a system, approved by the Finance Director, for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods;

(h) any evidence of significant overstocking and of any negligence or malpractice shall be reported to the Finance Director;

(h) losses and the disposal of obsolete stock are reported to the Finance Director

11.4 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

11.5 For goods supplied via the NHS Supply Chain central warehouses and in accordance with the Reservation of Powers and Scheme of Delegation, the Chief Executive shall identify those authorised to requisition and accept goods from the store, and issue appropriate guidance for checking receipt of goods.

12 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 Disposals and Condemnations

12.1.1 The Finance Director must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

12.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate. The Finance Director shall ensure that the arrangements for the sale of disposable assets maximise the income to the Trust.

12.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director;

(b) recorded by the Condemning Officer in a form approved by the Finance Director that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.

12.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

12.2 Losses and Special Payments

12.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Finance Director must also prepare a Fraud and Corruption Policy that sets out the action to be taken both by the persons detecting a suspected fraud and those persons responsible for investigating it.

12.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Finance Director or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Finance Director and/or Chief Executive. When an employee discovers or suspects fraud or corruption it must be immediately reported to the Trust's Local Counter Fraud Specialist. Alternatively, employees can contact the NHS Fraud and Corruption Reporting Line – 0800 028 40 60.

Where a criminal offence is suspected, the Finance Director must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Finance Director or Local Counter Fraud Specialist must inform the relevant CFOS regional team in accordance with the Secretary of State's Directions.

12.2.3 The Finance Director or Local Counter Fraud Specialist must notify NHS Protect (previously known as the NHS Counter Fraud and Security Management Service) and both the Internal and External Auditor of all frauds.

12.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Finance Director must immediately notify:

(a) the Board of Directors,

(b) the External Auditor, and

(c) the Head of Internal Audit.

12.2.5 The Audit Committee shall receive a report of losses and Special Payments. The delegated limits for approval of all losses and special payments are set out in the Reservation of Powers and Scheme of Delegation document. Authorising officers must undertake fuller reviews of systems to reduce the risk of similar losses occurring in the future and seek advice where they believe a particular case raises issues of principle.

12.2.6 For any loss, the Finance Director should consider whether any insurance claim could be made.

12.2.8 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded. This register will be reviewed by the Audit Committee on an annual basis.

12.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Treasury.

12.3 Bankruptcies, Liquidation and Receiverships

12.3.1 The Finance Director shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

12.3.2 When a bankruptcy, liquidation or receivership is discovered, all payments should cease pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

13 COMPUTERISED FINANCIAL SYSTEMS

13.1 The Finance Director, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's financial data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over financial data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the financial computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the financial computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

13.2 The Finance Director shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

13.3 In the case of computer systems which are proposed General Applications (i.e. including those applications which the majority of NHS bodies in the locality/region wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

13.4 The Finance Director shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during

processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

13.5 Where another health organisation or any other agency provides a computer service for financial applications, the Finance Director shall periodically seek assurances that adequate controls are in operation.

13.6 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that an audit trail exists;

(c) Finance Director staff have access to such data; and

(d) such computer audit reviews are being carried out as are considered necessary.

14 PATIENTS' PROPERTY

14.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

14.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

14.3 The Finance Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

14.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Finance Director.

14.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

14.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

14.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

14.8 Where a deceased patient is intestate and there is no lawful next-of-kin, details of any monies or valuables should be notified to the Treasury Solicitor.

14.9 Any funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of the patient's monies held by the Trust.

15 CHARITABLE FUNDS

15.1 Introduction

15.1.1 Charitable funds are those funds which are held in the name of the Trust separately from other funds and which arise principally from gifts, donations, legacies and endowments made under the relevant charities legislation.

15.1.2 Standing Orders state the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission for charitable funds held on trust and to Monitor for all funds held on trust.

15.1.3 The reserved powers of the Board of Directors and the Charitable Funds Scheme of Delegation make clear where decisions regarding the exercise of discretion in terms of the disposal and use of funds are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

15.1.4 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

15.1.5 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

15.2 Income

15.2.1 All gifts and donations accepted shall be received and held in the name of the Trust’s registered charity and administered in accordance with the Charity’s’s policy, subject to the terms of the specific charitable funds.

15.2.2 All managers/employees who receive enquiries regarding legacies shall keep the Finance Director, or person nominated by him, informed and shall keep an appropriate record. After the death of a benefactor all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Finance Director.

15.2.3 The Finance Director shall advise the Board of Directors on the financial implications of any proposal for fund raising activities which the Trust may initiate, sponsor or approve.

15.2.4 New charitable funds will only be opened where the wishes of benefactors cannot be accommodated within existing funds and in all cases must comply with the requirements of the Charity Commission.

15.3 Expenditure

All expenditure from charitable funds, with the exception of legitimate expenses of administering and managing those funds and expenditure for research purposes, must be for the benefit of the NHS.

15.3.1 Expenditure of any charitable funds shall be conditional upon the goods and services being within the terms of the appropriate charitable fund and upon the proviso that the expenditure does not result in further payments by the Trust which have not been agreed and funded.

15.4 Investments

15.4.1 Charitable funds shall be invested by the Finance Director in accordance with the Trust's policy and statutory requirements.

15.4.2 In managing the investments the Trust shall take due account of the written advice received from its duly appointed Investment Advisors.

16 ACCEPTANCE OF GIFTS BY STAFF

16.1 The Finance Director shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff.

17 RETENTION OF DOCUMENTS

17.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines " Records Management: NHS Code of Practice".

17.2 The documents held in archives shall be capable of retrieval by authorised persons.

17.3 Documents held in accordance with Department of Health guidelines shall only be destroyed at the express instigation of the Chief Executive and records shall be maintained of documents so destroyed. All the above shall be in compliance with the requirements of the Freedom of Information Act and the Trust's policy for document management and retention.

18 RISK MANAGEMENT

18.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with the terms of the licence issued by Monitor. This programme will be approved and monitored by the Board of Directors.

18.2 The programme of risk management shall include:

a) a process for identifying and quantifying principal risks and potential liabilities, existing controls, additional controls as identified in the corporate risk register;

b) engendering among all levels of staff a positive attitude towards the control of risk as described in the Trust Risk Management Strategy;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) review arrangements including; external audit, internal audit, clinical audit, health and safety review;

f) receive and review annual plan at Board of Directors.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by the guidance issued Monitor.

18.3 The Board of Directors shall review insurance arrangements for the Trust.

APPENDIX 1

THRESHOLDS FOR EU PUBLIC CONTRACTS REGULATIONS 2006 - FROM 1 JANUARY 2014

	SUPPLIES	SERVICES	WORKS
Entities listed in Schedule 1[1]	£111,676 (€134,000)	£111,676[2] (€134,000)	£4,322,012[3] (€5,186,000)
Other public sector contracting authorities	£172,514 (€207,000)	£172,514 (€207,000)	£4,322,012[3] (€5,186,000)
Indicative Notices	£625,050 (€750,000)	£625,050 (€750,000)	£4,322,012 (€5,186,000)
Small lots	£66,672 (€80,000)	£66,672 (€80,000)	£833,400 (€1,000,000)

CONSEQUENCES OF BREACHING THE EU REGULATIONS

A breach of the UK Public Contracts Regulations 2006 (currently being transposed into new legislation), the Public Contracts (Amendment) Regulations 2009 and the EU Public Contracts Directive 2014/24/EU is a serious matter whereby a fine is levied and/or reputational damage is done to the Trust.

When might a breach occur?

A breach may occur if the regulations have not been followed and is likely to be by one of the following happening;

1. The Trust has directly awarded a contract without placing an OJEU advertisement in circumstances where an OJEU advertisement is required by the legislation. E.g. Inappropriate use of a Single Tender Action Waiver
2. The Trust has breached the rules relating to the standstill period and that breach has denied the supplier an opportunity to challenge the contract award.
3. A call-off from a contract under a framework agreement for goods or services with a value over the EC procurement threshold has been entered into without following the relevant call-off procedures under that framework.

What might happen if we do breach?

Any contract will be deemed to be 'Ineffective'. Ineffectiveness is only available for procurements commenced on or after 20 December 2009. In such procurements, the three main circumstances outlined above may mean a remedy may be available to suppliers

What remedies are available to suppliers if we are found to have breached the Regulations?

If a court finds that the Regulations have been breached, it may render the contract ineffective or shorten the contract (possibly due to our requirements being critical and life-saving) and fine the Trust. In addition, a bidder may claim damages for its losses resulting from the breach.

When could we be fined?

A court is required (has no discretion) to impose a fine (described in the legislation as a "civil financial penalty") in any circumstances where the court declares a contract ineffective.

What will the level of fine be?

There is no prescribed "tariff" for fines however, the Regulations do state that fines must be "effective, proportionate and dissuasive". A figure of 10% of revenue has been used as a guide. A 1% (of revenue) fine for our Trust would be £4M.

York Teaching Hospital NHS
NHS Foundation Trust

RESERVATION OF POWERS

AND

SCHEME OF DELEGATION

Author: Foundation Trust Secretary
Owner: Chief Executive
Publisher: Compliance Unit
Date of Issue: January 16
Version: 9
Approved By: Audit Committee and Board of Directors
Review date: December 2016

Table of content

Reservation of Powers to the Board of Directors and Delegation of Powers

Introduction

The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board of Directors. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the Board of Directors expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive or other Executive Directors. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

Purpose

1.1 The purpose of this document is to define the control framework set by the Board for committing trust resources. The Board reserves certain matters to itself which are set out in the Schedule of Matters Reserved to the Board. The Scheme of Delegation identifies which powers and functions the Chief Executive shall perform personally and those which he has delegated to other Directors and Officers.

1.2 All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. In the absence of the Chief Executive the powers of the Chief Executive are delegated to the Deputy Chief Executive.

1.3 The Scheme of Delegation shows only the top level of delegation with the Trust. The Scheme is to be used in conjunction with the Trust's Standing Orders, Schedule of Matters Reserved to the Board, Standing Financial Instructions including the system of budgetary control and other established policies and procedures within the Trust.

1.4 In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that Director of Officer's superior unless alternative arrangements have been approved by the Board. If the chief Executive is absent, powers delegated to him may be exercised by the Director who has been duly authorised to act up for him taking appropriate advice from the Chairman.

Scope

2.1 To ensure that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures.

2.2 The Scheme of Delegation is consistent with the NHS Code of Conduct and Accountability and Monitor's Code of Governance. Directors and Officers are reminded

that powers are delegated to them on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern. The Code of Conduct of Accountability in the NHS and the Code of Governance sets out the core standards of conduct expected of NHS managers.

2.3 Provide details of delegated limits to all officers holding responsibilities. Budget Holders agree to operate within the budget limit and within the delegated limits as outlined in this document. It is their responsibility to manage within their budget and to identify any changes to the budget assumptions surrounding activity, timing and staffing issues which may result in changes to financial risk. If a proposed transaction is beyond their authority and outside the Annual Plan, it should be referred to their manager. Failure to do so may result in disciplinary action.

2.4 The document forms part of the Trust's corporate governance framework, which is the regulatory framework for the business conduct of the Trust within which all Trust officers are expected to comply. The aim is not to create bureaucracy but to protect the Trust's interests and to protect staff from any accusation that they have acted less than properly. It does this by ensuring that all staff, particularly budget managers and authorised signatories are aware of their authorities and responsibilities for compliance with the relevant procedures. The key documents in this framework include the following and should be read in conjunction with the Reservation of Powers by the Board of Directors and Delegation of Powers:

- Standing Orders.
- Standing Financial Instructions

Principles of the Scheme of Delegation

3.1 Principles that are followed by the Scheme of Delegation

- There is no spend beyond authorised limits except with the approval as appropriate
- The business case process is mandatory.

Governors' legal responsibilities

4.1 The Trust has a body of elected individuals that make up the Council of Governors. Governors have a number of legal rights and responsibilities. These include:

- The appointment or dismissal of the Chairman and Non-executive Directors
- The approval of the appointment of the Chief Executive
- At a general meeting the Council of Governors will:
    - receive the annual accounts annual report and Quality Report and annual audit letter from the external auditors
    - approve the remuneration and allowances and other terms and conditions of the office of the Chairman and Non-executive Directors
    - appoint or replace the Trust's auditor at a general meeting
- Providing the views of the Council of Governors to the Board of Directors for the purposes of the preparation by the Board of Directors of the document containing information as to the Trust's forward planning in respect of each Financial Year to be given to Monitor
- Receiving and considering the views of the Members on matters of significance to the future plans of the Trust
- Approval of the amended of the constitution

- Hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors
- Represent the interests of the NHS Foundation Trust members and the public served by the Trust
- Approving significant transactions that fall within the definition
- Appointment and removal of the External Auditors
- Approval of the increase of non- NHS income where it is 5% or more in any one year

Scheme of matters reserved for the Board

5.1 General enabling provision

The Board may determine any matter (for which it has delegated or statutory authority) it wishes in full session within its statutory powers, subject to any restrictions contained in the Trust's Constitution and/ or terms of the Licence.

5.2 Constitutional Powers

- To exercise all powers of an NHS foundation trust set out in the NHS Act 2006, subject to any restrictions in the Trust's Licence; enforcement undertakings given to regulators or as delegated in accordance with this Scheme of Delegation. (Constitution paragraph 4)
- Determine the composition of the Board of Directors (Constitution paragraph 9)
- Make available for inspection by members of the public the following: register of Members; register of members of the Council of Governors; register of interest of members of the Council of Governors; register of members of the Board of Directors; register of interests of members of the Board of Directors; Constitution; Licence; latest Annual Accounts and Auditor's report on them; latest Annual Report and Forward Plan; and any notice issued by the Monitor under Section 52 of the NHS Act 2006.
- Appoint the Returning Officer
- Approve payment of expenses and remuneration to Returning Officer
- Make available for inspection by members of the public statements of nominated candidates and nomination papers.
- Approve and deliver to the Returning Officer a list of Members eligible to vote
- Retain documents relating to elections to the Council of Governors and make these for inspection by members of the public, subject to any restriction in the Election Rules.
- Approve proposals to amend the Constitution which must be approved by the Council of Governors.
- Specify Partnership Organisations
- Receive and determine disputes under the Constitution, including disputes between the Council of Governors and the Board of Directors.
- Present Annual Accounts, any reports of the Auditor on them and the Annual Report at the Annual General Meeting.
- Prepare the Annual Report
- Prepare the Forward Plan

5.3 Regulation and controls

- Approval, suspension, variation or amendment of Standing Orders, Reservation of Powers and Delegation of Powers and Standing Financial Instructions for the regulation of its proceedings and business
- Approval of the Reservation of Powers and Delegation of Powers from the Board to officers
- Requiring and receiving the Declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration
- Requiring and receiving declaration of interest from officers which may conflict with those of the Trust.
- Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property
- Approval of the arrangements for dealing with complaints
- Adoption of the organisational structure, processes and procedures to facilitate the discharge of business by the Trust and to agree any modification there to
- To establish terms of reference and reporting arrangements of all committees established by the Board of Directors
- To receive reports from committees including those which the Trust is required to provide by the Secretary of State, Monitor or other regulatory body or regulation to establish and to take appropriate action thereon
- To confirm recommendations presented to the Board of Directors by the Trust's Committees
- Ratification of any urgent decisions taken by the Chairman in accordance with Standing Orders
- Approve the Trust's Major Incident Plan
- Prescribe the Financial and Performance reporting arrangement required by the Board of Directors
- Approval of arrangements relating to the discharge of the Trust's responsibility as a corporate trustee for funds received in trust and Funds Held on Trust
- Approval of the Trust's banking arrangements (SFI 5.2)
- Authorise use of the common seal of the Trust (SO10)
- Ratify or otherwise instances of failure to comply with Standing Orders (SO3.13)
- Discipline members of the Board of Directors or Officers who are in breach of statutory requirements or Standing Orders
- Call meetings of the Board of Directors (SO3.1)
- Resolve to require withdrawal of the press and public from meetings of the Board of Directors
- Approve minutes of the proceedings of the meetings of the Board of Directors (SO 3.12)
- Resolve to adjourn any meeting of the Board of Directors

5.4 Appointments/ Dismissal

- The appointment and dismissal of Board Committees
- The appointment of the Vice Chairman in consultation with the Council of Governors
- The appointment of the Senior Independent Director in consultation with the Council of Governors
- Through the Remuneration Committee the appointment and appraisal of Executive Directors and the disciplinary procedures of the Trust
- Ratification of the appointment of senior medical staff

- Approval of all new consultant appointments related to a business case
- The appointment of membership of the Board sub-committees
- The appointment of any representative body outside the organisation

5.5 Policy Determination

- The Board of Directors will approve policies that require specific Board approval including:
    - Management of Risk
    - Fire Safety Policy
    - Health and Safety Policy
    - Security Policy

This is not an exhaustive list.

5.6 Strategy and plans

- Define and approve the strategic aims and objectives of the Trust
- Approve strategic business plans incorporating a programme of investment in respect of the application of available financial resources
- Approve proposals for ensuring quality and safety and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State
- Approve annually Trust budgets (SFI 3.1.1)
- Approve final business cases for the use of private finance for capital schemes (SFI 10.2)
- Approve proposals for action on litigation against or on behalf of the Trust
- Review use of NHSLA risk pooling schemes, commercial insurers and self-insurance (SFI 18.3)

5.7 General matters

- Acquisition, disposal of land/ or buildings above a value of £1m.
- Change of use of land
- Joint ventures
- To agree actions on litigation against or on behalf of the Trust
- Any investment regardless of size of new activity or any disinvestment
- Purchase and maintain insurance against liability.
- Approve opening and closing of any bank or investment account (SFI 5.1.3)
- Approve proposals for action on litigation against or on behalf of the Trust

5.8 Financial and reporting management arrangements

- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust
- Consideration and approval of the Trust's Annual Report and Annual Accounts prior to submission to Parliament
- Receive the annual management letter from the external auditor and agree proposed action taking account of the advice, where appropriate, of the Audit Committee

Summary of Delegated Authorities

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders. All reference material is available from staffroom

General Area	Delegated matter	Authority delegated to	Scope of Delegation	Details/ Reference
Accountability	Accountable through NHS Accounting Officer to Monitor for the stewardship of Trust Resources	Chief Executive	Full	Accountable Officer Memorandum
	Ensure the expenditure by the Trust complies with Monitor requirements	Chief Executive	Full	Accountable Officer Memorandum
	Ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness	Chief Executive Finance Director Foundation Trust Secretary		
	Delivery of the Turnaround Avoidance Programme – Delivering Success	Chief Executive		
Declaration of Interests	The keeping of a declaration of board members and officers' interests	Foundation Trust Secretary		SO 6
Receipt of Gifts and Hospitality	Receipt or provision of hospitality and gifts	All Trust employees have a duty to declare		Standards of business conduct policy
	Approve procedures for declaration of hospitality and sponsorship	Board of Directors		
	Maintenance of gifts and hospitality register	Foundation Trust Secretary		
	Approval of receipt of both individual and collective hospitality	Prime budget holder		
Financial Procedures and Trust	Approve and communicate all financial procedures and Trust accounting policies	Finance Director Audit Committee	All	FReM and Monitor guidance

accounting policies				SFI 1.1.3
Asset Register	Maintenance of the asset Register	Chief Accountant	All	SFI 10.3
Investment of funds	Investments – Annual programme agreed by the Board of Directors	Finance Director	All	Treasury Management Policy
Capital Investment and Business Cases		Capital Programme Executive Group	Up to £100k	SFI 10
		Chief Executive & Finance Director through Capital Programme Management Group	£100k-£500k	
		Executive Board	£500k - £1m	
		Board of Directors	Over £1m and all PFI proposals	
All Business Cases revenue investment	Captured in the business cases (Any expenditure over £25k must be advertised under procurement rules. Further advice should be sought from procurement)	Prime budget holder	Up to £50k	
		Chief Executive	£50k - £500k	
		Executive Board	£300k-£1m	
		Board of Directors	Over £1m and all PFI proposal	
Expenditure variations on capital schemes	Variations	Capital Programme Management Group	Up to 10k	SFI 10
		Chief Executive and Finance Director through Capital Programme Executive Group	Up to £300k	
		Executive Board	Up to £500k	
		Board of Directors	Unlimited	
Planning & Budgetary	Prepare and submit an Annual Plan	Finance Director		SFI

Control	Management of budgets for the totality of services	Chief Executive		SFI
	At Directorate level Prime budget holders are clinical directors and directors who hold all operating budgets for the Directorate's they manage including, where appropriate, income, activity and expenditure. Directorate Managers who provide professional support to practising Clinical Directors have also been granted Prime budget holder status.	Prime budget holder		Trust Finance Manual Section 8
	At individual budget unit level (pay and non pay) Prime budgets holders can delegate budgetary authority to delegated budget holders. These are typically lead clinicians, senior and other operational managers who control budgets on a day to day basis.	Delegated budget holder		Trust Finance Manual Section 8
	Virement (planned transfer) of resources between directorate or specialty/department budgets (per annum):	Finance Director		SFI Trust Finance Manual Section 8.2.3
	Non pay requisitions – Decisions to rent or lease in preference to outright purchase	Head of Corporate Finance		SFI
	Authority to change clinical template activity	Chief Operating Officer and Finance Director		
Non-pay revenue expenditure within budgets (Note: over £50K the Business Case procedure shall apply)		Prime budget holder (if within available budget resources as agreed with the Finance Director)	Prime budget holders are expected to set delegated limits for delegated budget holders and advise the Head of Corporate Finance for inclusion in	SFI Trust Finance Manual Section 5.2 Section 8.2.1

			the authorised signature list	
	Medical equipment (i.e. medical, scientific, technical and x-ray equipment) – individual items. Funding to be managed within Capital Programme allocation	Medical Equipment Resource Group (MERG)	over £1k and up to £50K supported by a MERG Form	
	Establishment of escalation facilities at short notice and associate costs	Chief Operating Officer		
	Non-pay expenditure for which no specific budget has been established and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above).	Finance Director		SFI 9.2.6(e)
	Purchasing Cards: Authority to issue purchasing cards and setting of limits	Prime budget holder		
Quotations, Tendering and Contracts	Obtaining a minimum of 3 written competitive tenders for goods/services over £25K	Head of Procurement	Over £25k	
	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders)	Head of Procurement Chief Executive	Under £50k Over £50k	SFI 9.5
	Opening tenders – manual	All Executive Director and the Foundation Trust Secretary		SFI 9.5
	Opening tenders – electronically the system prevents quotes/tenders from being opened before the deadline	Head of Procurement		
	Acceptance of quotations/ permission to consider late quotations	Head of Procurement	Under £50k	

	Acceptance of tenders/permission to consider late tenders	Chief Executive	Over £50k	SFI 9.5
	Accepting contracts and signing relevant documentation	Head of Procurement Chief Executive and Finance Director	Under £50k Over £50k	
Attestation of sealing in accordance with standing orders	Attestation of sealing	Chairman or designated NED and Chief Executive or designated Executive Director	All	SO10
	The keeping of the seal	Foundation Trust Secretary		
Insurance policies	Insurance	Head of Corporate Finance		
	Review of all statutory compliance legislation and Health and Safety requirements including Control of Substances Hazardous to Health Regulations	Health and Safety Manager		
Bank accounts and loans	Loan arrangements	Finance Director		SFI 5
Petty cash disbursements	Expenditure	Petty cash holder	Up to £50 per item	
		Finance Director	Over £50 per item	
	Reimbursement of patient monies	Delegated budget holder	Up to £250	
		Prime budget holder	Over £250	
Property transactions	Disposal and acquisition of land and buildings	Chief Executive, Finance Director Capital Programme Management Group	Up to £500k	SFI
		Executive Board	£500k - £1m	
		Board of Directors	Above £1m	

	Lets and Leases			
	Preparation and signature of all tenancy agreements/ licenses for all staff subject to Trust Policy on accommodation for staff	Director of Estates and Facilities		
	Extensions to existing leases	Director of Estates and Facilities		
	Letting of premises to outside organisations, subject to business case limits	Director of Estates and Facilities		
	Approval of rent based on professional assessment	Director of Estates and Facilities		
Setting of Fees and Charges	Private patient, overseas visitors, income generation and other patient related services	Finance Director		SFI 6.2.3 Provider Licence
	Financing content of NHS contracts	Finance Director		
	Approval of healthcare contracts and other agreements resulting in income to the Trust	Finance Director		
	Approval of variations of healthcare contracts:	Finance Director		
Losses and compensation	All losses, compensation and special payments shall be in accordance with current DOH guidance & details of all such payments shall be presented to the Audit Committee	Audit Committee		SFI
	Maintain a losses and special payments register	Finance Director		SFI
	Clinical Cases	Settled by NHS Litigation Authority		
	Non-clinical cases	Finance Director	Up to £50k	
		Chief Executive	£50k - £300k	

		Executive Board	£300k-£500k	
		Board of Directors	Over £500k	
	Review schedules of losses and compensations and make recommendations to the Board	Audit Committee		
	Special payments – outside the terms of any contract obligation	Treasury approval		
Condemning and disposal - Equipment	Items obsolete, obsolescent, redundant, and irreparable or cannot be repaired cost effectively (note: For disposal including those for sale the tendering and quotation limits shall apply)	Executive Director responsible for the area		SFI 12 Disposal and Transfer policy
Provision of services to other organisations	Legal and financial arrangements for the provision of services to other organisations and individuals	Director of Finance		SFI 6.2.3
	Signing agreement with other organisations and individuals			
Audit and Accounts	Approve the appointment and where necessary dismissal of the External Auditors	Council of Governors		SFI 4
	Receive the annual management letter from the External Auditor.			
	Receive the annual management letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee	Board of Directors		
	Receive an annual report from the Internal Auditors and agree action	Audit Committee		
Annual Report and Accounts	Receive and approve the Annual Report and Accounts and Quality Report	Board of Directors		SFI 4
	Receive the Annual Report and	Council of		

	Accounts and Quality Report and any comments on them at the Annual General Meeting	Governors		
	Sign the annual statements including the annual accounts on behalf of the Board of Directors	Chair, Chief Executive and Finance Director		
	Implementation of internal and external audit recommendations	Finance Director		SFI 2.2
Retention of Records	Maintaining archives of records to be retained	Chief Executive		SFI 17
Research and development	Approval of research and development contracts to be supported by a business case including workforce implications (including variations or extensions):	Medical Director or Finance Director or Chief Executive	Up to £300K	
		Executive Board	£300k -£1m	
		Board of Directors	£1m and over	
Personnel and Pay	Approve management policies including personnel policies incorporating arrangements for the appointment, removal and remuneration of staff	Chief Executive		
	Authorisation of timesheets (including agency timesheets)	Delegated budget holder		
	Agency nursing staff	Chief Nurse's Office		
	Authority to fill funded post on the establishment with permanent staff	Chief Executive		SFI 3.3
	Authority to appoint staff to post not on the formal establishment	Chief Executive		SFI 3.3
	Granting of additional increments to staff within the context of policy (HR process up to 2 incremental points	Deputy Director of HR	All subject to compliance with A4C regulations	SFI 3.3
	Above policy level	Chief Executive		
	Chief Executive and Director posts including Corporate and Executive Directors	Remuneration Committee Chairman of the Trust as Chair of the Remuneration		

		Committee		
	Non-executive Directors and Chair	Council of Governors		SO 2.2
	Upgrading and re-grading Subject to compliance with regulations	Deputy Director of HR		SFI 3.3
	Variations to existing consultant contracts/job plans Subject to compliance with regulations	Medical Director Deputy Director of HR and Chief Operating Officer		
	Authorising overtime	Delegated Budget Holder		SFI 8.4.3
	Authorising travel and subsistence	Delegated Budget Holder		
	Authority to pay clinical excellence awards to Consultants	Board of Directors endorse decision of Committee chaired by the Chief Executive or Deputy Director of HR		
	Authority to pay discretionary points to staff grade and associate specialist doctors	Medical Director and Deputy Director of HR		
	Consider and approve recommendations on behalf of the Board on the remuneration and terms of service of corporate directors to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff	Remuneration Committee		
	Approval of annual leave	Delegated budget holder		Annual Leave and Bank Holiday Policy and Procedure
	Annual leave – approval of carry forward			
		Delegated budget	Up to a	

		holder	maximum of 5 days:	
		Over 5 days:		
		Medical Director	Medical Staff	
		Prime budget holder	Other Staff	
	Approval of compassionate leave			Special Leave Guidance
		Delegated budget holder	Up to 5 days	
		Prime budget holder in consultation with HR	Up to 10 days	
	Special leave			Special Leave Guidance
		Delegated budget holder	Paternity	
		Delegated budget holder	Other	
		Delegated budget holder	Maternity leave	
		Delegated budget holder	Leave without pay	
		Chief Executive	Medical staff leave of absence – paid and unpaid	Special Leave Guidance
		Prime budget holder	Time off in lieu	Special Leave Guidance
		Delegated budget holder	Flexible working arrangements	Flexible Working Policy
		Deputy Director of HR	Extension of sick leave on half pay up to three months	Sickness Absence Policy

		Deputy Director of HR	Return to work part time on full pay to assist recovery	
	Study Leave			
		Clinical Director	Study leave outside the UK – medical	Learning Leave Guidance
		Prime budget holder	Study leave outside the UK – other	
		Clinical Director Delegated budget holder	Medical staff study leave (UK)	
		Delegated budget holder	All other study leave (UK)	
	Rent and House Purchases: Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)			Relocation Expenses Policy
		Prime Budget Holder	up to £6,000 (non-medical staff)	
		Director of Workforce and OD Medical Director	up to £6,000 (medical staff)	
		Director of Workforce and OD Medical Director Finance Director	£6,000 - £8,000	
		Chief Executive	Over £8,000	
	Requests for new posts to be authorised as car users or mobile phone users	Prime budget holder		Lease Car and Mobile Communication Equipment Policies

	Renewal of fixed term contracts Must be linked to business needs and available funding	Prime budget holder Deputy Finance Director		
	Authorisation of retirement on the grounds of ill health.	Deputy Director of HR (the decision can only be made by the NHS Pensions Agency)		
	Authorisation of staff redundancy	Finance Director Director of Workforce and OD		Redundancy Policy
		Finance Director (with HM Treasury approval where required)	Any termination settlement	
	Authority to suspend (non clinical) staff	Prime budget holder Deputy Director of HR		Disciplinary Policy and Procedure
	Authority to exclude clinical staff	Chief Executive		
	Authority to restrict practice	Chief Executive		MHPS guidance
	Authorisation of staff dismissal	Anyone reporting directly to a Director e.g. Directorate Manager/Head of service (or delegated deputy),Senior Nursing Team		
	Engagement of staff not on the establishment supported by a business case	Corporate Directors		
	Booking of bank and agency staff			
		Prime budget holder	Medical Locums	
		Prime budget holder and through the Chief Nurse's office	Nursing	

		Prime budget holder	Clerical	
Facilities for staff not employed by the Trust to gain practical experience	Professional recognition, honorary contracts and insurance of medical staff, work experience students	Deputy Director of HR and Medical Director		
Security and risk management	Corporate responsibility for implementation of the Security Policy	Director of Estates and Facilities		Security Policy
	Overall statutory responsibility for security management within the Trust	Chief Executive		
	Where an offence is suspected	Head of Security	Criminal offence of a violent or clinical nature	
		Head of Security (theft)/ Local Counter-Fraud Specialist (fraud)	Where a fraud or theft is involved	
	Authority for the issue of ID and security badges and car park passes	Delegated budget Holder		Security Policy ID Badge policy
Authorisation of new drugs	Yearly cost of drugs	Directorate managers	Estimated total yearly cost per individual drug up to £25,000	
		DTC recommendation, subject to business case procedure and Executive Board approval	Estimated total yearly cost per individual drug above £25,000	
	Authority to purchase/contract:			
		Senior Technician	Up to £5K	

		Countersigned by Principal Pharmacist	£5K - £50K	
		Countersigned by Chief Pharmacist	£50K - £100K	
		Finance Director	£100K to £150K	
		Chief Executive	£150K to £300K	
		Executive Board	£300K - £1m	
		Board of Directors	Over £1m	
	Approval of nurses and others to administer and prescribe medication beyond the normal scope of practice	Director of Nursing or Medical Director or Chief Pharmacist		Nurse, Midwives, HV Act, Midwives Rules/Codes of Practice, NMC Code of professional Conduct/CSP Rules of Professional Conduct
Patients and relatives' complaints	Overall responsibility for ensuring that all complaints are dealt with effectively	Head of Patient Experience		Concerns and Complaints Policy and Procedure
	Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly	Head of Patient Experience		Concerns and Complaints Policy and Procedure Complaints Policy
	Agreement of financial compensation	Finance Director		Losses procedure
Extra Contractual Payment	Authority to undertake and approval to pay waiting list initiatives	Finance Director or Chief Operating Officer		
Engagement of Trust's Solicitors		All Directors, Foundation Trust Secretary, Deputy Director of Healthcare Governance ,		

		Head of Procurement		

Blank page

York Teaching Hospital NHS
NHS Foundation Trust

Board of Directors – 27 January 2016

Business Case: 2015-16/32 - Development Of Theatre 10

Action requested/recommendation

The Board of Directors is asked to approve the business case.

Summary

The purpose of the Business Case is to request approval for funding for the resources required to provide an interventional laboratory facility in the current theatre 10 space. Also to provide an additional interventional radiologist and vascular surgeon in order to be compliant as a vascular imaging centre under NHS England recommendations.

Approval of the Business Case will ensure the department is well positioned to be compliant as a vascular centre, as commissioned by NHS England. Development of this vascular laboratory will, in reducing patient waiting times, have a positive effect on achieving the 18 week target for referring specialities and will ensure the service can meet current demands thus improving the patient experience as well as providing financial benefits to the Trust through income and avoiding financial penalties.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☒

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups

identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes

Progress of report	Corporate Directors Executive Board Board of Directors
Risk	The risk of not proceeding with the above case will be the Radiology Directorate and Organisation's failure to achieve compliance in relation to vascular centre status and 18-week RTT etc. leading to a poorer patient experience. The Trust will also continue to incur financial penalties relating to these non-compliances.
Resource implications	Resources implication detailed in the report.
Owner	James Haselden, Clinical Director – Radiology
Author	Steven Mackell, Directorate Manager – Radiology
Date of Paper	January 2016
Version	1

APPENDIX Bi

York Teaching Hospital NHS
NHS Foundation Trust

For Director of Finance Use Only			
Self-Assessed PIR		Full PIR	

BUSINESS CASE SUMMARY

1. Business Case Number

2015-16/32

2. Business Case Title

Development Of Theatre 10 To Provide Vascular Interventional Radiology Lab In Theatre Environment, Appointment Of 6th Interventional Radiologist and 6th Consultant Vascular Surgeon

3. Management Responsibilities & Key Contact Point

The business case 'Owner' should be the appropriate Clinical or non-clinical Director, or where appropriate the lead Clinician nominated by the respective Clinical Director. The 'Author' will be the named manager supporting the Owner of the business case, who will have responsibility for the development and writing of the business case, and will be the key contact point for enquiries.

Business Case Owner:	**J. Haselden**

Business Case Author:	**S. Mackell**
Contact Number:	**X5563**

4. Issue(s) to be addressed by the Business Case

Describe the background and relevant factors giving rise to the need for change. Relevant data (e.g. BCBV data, etc.) *must be included to support the background described.*

To be compliant as a vascular centre, as commissioned by NHS England, there is a requirement to have 6 interventional consultants and 6 consultant vascular surgeons in order to provide a 1:6 on call service. The current 1:5 on call service for both radiology and surgery is not compliant and puts our status as a vascular centre at risk.

The capacity within the current vascular and interventional lab has reached its maximum and the procedures undertaken within the lab have become more complex, coupled with

an increase in therapeutic procedures and combined vascular interventional Radiology with open surgery. With increased complexity comes an increase in procedure duration. Procedures such as Endovascular aneurysm repair (EVAR) can take up to a ½ day of lab time. EVAR reduces the 30-day operative mortality by two-thirds compared with open surgery. Thus, EVAR is superior in terms of saving lives.
The increase in time and the urgent nature of these procedures effects booked interventional appointments causing cancelation / postponement creating breaches in diagnostic and treatment targets. This necessitates the use of expensive WLI to manage the elective waiting list as well as increasing acute inpatient stay.
By creating a vascular lab in the current theatre 10 space, EVAR procedures will be undertaken here and the interventional lab can continue to operate, eliminating the need to cancel booked appointments and reduce the acute wait and inpatient stay.

Having ready access to permanent anaesthetic facilities will increase safety and enhance patient care.

Development of this vascular lab will, in reducing patient waiting times, have a positive effect on achieving the 18 week target for referring specialities. There are currently breaches of the 6 week diagnostic and 18 week Referral to Treatment targets due to lack of capacity within VIU.

As an accredited vascular centre the trust is required to ensure that an on-site contingency is available should equipment failure occur.

5. Options Considered

List below the alternative options considered to resolve the issue(s) presented in section 4 above. This should include consideration of alternative workforce and clinical models.

Description of Options Considered
Option 1 -Do nothing
Option -2 Development of Theatre 10 to vascular lab, appoint interventional radiologist and consultant vascular surgeon

6. The Preferred Option

6.1 Preferred Option

Detail the preferred the option together with the reasons for its selection. This must be supported with appropriate data in demonstrating how it will address the issue(s) described in section 4 above.

Option -2 Development of Theatre 10 to vascular lab and appoint interventional radiologist
Appointment of a 6th consultant vascular surgeon will increase provision of EVAR and other main theatre cases. There will be an increase in day case operating at Bridlington

which will decrease the wait for varicose veins treatment on the East Coast. There will be greater presence at Harrogate with increased outpatient clinics to reduce the outpatient wait. This in turn will reduce breaches of the 18 week referral to treatment target as these patients are operated on in York.

This appointment makes the on call model more sustainable (move from 1 in 5 to 1 in 6). Furthermore, it allows us to implement the recommendations of a recent NCEPOD audit which demonstrated that our rates for foot amputations are very high when compared to our peers. It was recommended that multi-disciplinary diabetic foot clinics are established at all sites in order to provide early intervention to prevent amputation. The appointment allows us to establish clinics on the Harrogate and Scarborough sites in addition to the York clinic.

6.2 Other Options

Detail the reasons for rejecting the remaining options listed under section 5, together with supporting detail.

7. Trust's Strategic Objectives

7.1 Alignment with the Trust's Strategic Objectives

The Trust has identified four strategic 'frames' that ensure there is a focus for its emerging priorities and objectives and assists in the communication to staff, patients and other stakeholders. The four strategic 'frames' are:

1 *Improve Quality and Safety*
2 *Develop and enable strong partnerships*
3 *Create a culture of continuous improvement*
4 *Improve our facilities and protect the environment*

In this context listed below are four principle objectives that fit to the strategic frames. Indicate using the table below to what extent the preferred option is aligned with <u>at least one</u> of these principle objectives.

Strategic Objective	Aligned? Yes/No	If Yes, how is it Aligned?
Improve quality and safety - To provide the safest care we can, at the same time as improving patients' experience of their care. To measure our provision against national indicators and to track our provision with those who experience it.	Y	Procedures will be undertaken within the appropriate time scale without pressure to overbook. Acute/critical patients seen in a timely manner. Availability of full permanent anaesthetic facilities when required.
Develop and enable strong partnerships - To be seen as a good proactive partner in our communities	Y	As a vascular centre for the region commissioned by NHS England the team work in partnership with teams

- demonstrating leadership and engagement in all localities.		in Hull, Harrogate and Scarborough
Create a culture of continuous improvement - To seek every opportunity to use our resources more effectively to improve quality, safety and productivity. Where continuous improvement is our way of doing business.	Y	Development of improved service by reduction in waiting times and better access to acute intervention. Reduction in payment for WLI and reduction in fines for breaching
Improve our facilities and protect the environment - To provide a safe environment for staff, patients and visitors, ensuring that all resources are used as efficiently as possible.	Y	The workload will be balanced across the facilities making the working environment less cramped and improve the patient flow and experience

7.2 Business Intelligence Unit Review

The Business Intelligence Unit must review all business cases for 'Strategic fit' to the Trust's 5 year plan. The date that the business case was reviewed by the BIU together with any comments which were made must be provided below.

Date of Review	
Comments by BIU	

8. Benefit(s) of the Business Case

8.1 Benefit(s)

The identification at the outset of the benefit(s) that arise from the business case is crucial to ensuring that a robust evaluating of the progress and delivery of the business case objectives is possible during the post implementation reviews.

*Clearly detail and **quantify** the expected benefits that will accrue to the Trust from the preferred option in each of the three domains of service improvement. The benefits identified must be tangible, and capable of being evidenced ideally through some form of measurement.*

Description of Benefit	Metric	Quantity Before	Quantity After
Quality & Safety			
Compliance with NHS England requirements for a specialist vascular service with 6 interventional Radiologists and 6 Consultant Vascular Surgeons		5	6
How will information be collected to demonstrate that the benefit has been achieved? Head Count			
Access & Flow			
Increased access to interventional clinics		10	15
With the use of TH 10 to perform EVAR this frees		0	120

appointment slots for other interventional procedures			
Improve performance against the non-admitted RTT 92% target for General Surgery	%	92.55%	Over 94%
How will information be collected to demonstrate that the benefit has been achieved? Additional appointment slots made available			
Finance & Efficiency			
Reduction in WLI payments		Previous yearly total = 10 sessions (7 staff each session)	0
How will information be collected to demonstrate that the benefit has been achieved? Staff returns			

8.2 Corporate Improvement Team Review

The Corporate Improvement Team must review all business cases across the three quality domains. The date that the business case was reviewed by the CIT together with any comments which were made must be provided below.

Date of Review	
Comments by CIT	

8.3 Corporate Efficiency Team Review

The Corporate Improvement Team must review all business cases for efficiency opportunities. The date that the business case was reviewed by the CET together with any comments which were made must be provided below.

Date of Review	
Comments by CET	

9. Summary Project Plan

Detail below the specific actions, individuals responsible for their delivery, and timescales that must be done in order to realise the intended benefits of the preferred option of this business case. For example, these may include acquisition of key space requirements, or equipment, IT software/ hardware; the recruitment of key personnel, training, implementation of systems, change in business and/or clinical processes, etc. ***All fields must be completed****.*

Description of Action	Timescale	By Who?
Discussions with key players and stakeholders at various times throughout scheme	2013 - August 2015	All key players and stakeholders
Development of Business Case	July 15 -	Alison

	December 2015	MacDonald, Debbie Brian, Steven Mackell Paul Roth
Passage through Corporate Directors and Executive Board	January 16	Steven Mackell,
Supplier product demonstration and technical evaluation	-November 15	Radiographers, Interventional radiologists, Cardiologists, Suppliers
Equipment procurement process	May 2016	Steven Mackell, Liz Hodges, Liz Picken, Purchasing, Sarah Hogan, NHS Supply Chain Capital Planning
Enabling works in Theatre 10 space to allow change of use to vascular Lab. Negotiation re utilisation of storage space in and around the theatre suite On capital plan for 2014-15	November 15 – July / August16	Estates Capital planning team Alison MacDonald Steven Mackell
Delivery & installation of equipment and IT and PACS connectivity works	September / October 16	Supplier, Capital Planning, Purchasing, S&NS, Tom Skidmore, Estates
Applications training followed by implementation of new equipment for patient examinations and procedures	October / November 16	Radiographers, Radiologists Alison MacDonald Suppliers
Appointment of 6th Interventional Radiology consultant	October 16	Steven Mackell James Haselden

10. Risk Analysis:

Identify the key risks to the Trust of proceeding with the preferred option, and what actions can be taken to mitigate them should they arise.

Identified Risk	Proposed Mitigation
Delays in evaluation process, delivery, building works etc.	Continue to provide WLI clinics where required
Insufficient space within the Theatre 10 environment to accommodate imaging equipment requirements	Negotiation to utilise storage space around theatre 10 suite for location of electrical supply cabinets.
Recruitment and training Challenges	Actively recruiting and training in preparation.
No additional recovery space is provided within the development of Theatre 10	The acute patients treated in room 10 are already resident in the bed stock and will be recovered in the ward areas

11. Risk of Not Proceeding:

Identify the key risks/ potential impact of not proceeding with the preferred option.

Non Compliance with NHS England requirements for vascular centre resulting in
Loss of vascular centre status for the region.
Loss of vascular and interventional imaging within the Trust
Loss of income to the Trust
Loss of Trust reputation
Delay to the treatment of elective patients exerting pressure upon the 18 week target for referring specialities.
Delay to the treatment of elective and acute patients resulting in a lesser outcome for the service user.
Lesser outcome resulting in further procedures increased bed days which effects wider business of the Trust

12. Consultant, and other Non-Training Grade Doctor Impact

(Only to be completed where the preferred option increases the level of Consultant/ non-Training Grade input)

12.1 Impact on Consultant/ Non-Training Grade Doctor Workload:

The Trust is committed to reduce the number of Programmed Activities (PAs) being worked by any Consultant/ Non-Training Grade Doctor to a maximum of 11. This section should illustrate the impact that the additional Consultant/ Non-Training Grade input created will have on the average number of PAs worked in the specialty, the frequency of the on-call rota, and the PA profile across the whole specialty team. Information is also required of each Consultant's/ Non-Training Grade Doctor's actual annual working weeks against the 41 week requirement.

The information below must be accompanied by the Trust's Capacity Planning Tool, and the Job Plan, which should be appended to, and submitted with the business case.

RADIOLOGY

	Before	After
Average number of PAs	11	11
On-call frequency (1 in)	1:5	1:6

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Dr T Bowker	**41**	**41**	**11**	**11**
Dr J Poels	**41**	**41**	**11**	**11**
Dr B Almazedi	**41**	**41**	**11**	**11**
Dr M Nichols	**41**	**41**	**11**	**11**

D N Warnock	**41**	**41**	**11**	**11**
Additional consultant	**41**	**41**	**11**	**11**

SURGERY

	Before	After
Average number of PAs	12	12
On-call frequency (1 in)	1:5	1:6

Consultant/ Non-Training Grade Doctor Team Work Profile				
Name of Consultant/ Non-Training Grade Doctor	**Working Weeks v 41 Week Requirement**		**PA Commitment**	
	Before	**After**	**Before**	**After**
Mr S Cavanagh	**41**	**41**	**12**	**12**
Mr M Baroni	**41**	**41**	**12**	**12**
Mr S Brooks	**41**	**41**	**12**	**12**
Mr A McCleary	**41**	**41**	**12**	**12**
Mr A Thompson	**41**	**41**	**12**	**12**
Additional consultant	**41**	**41**	**12**	**12**

12.2 Advisory Committee Review:

The Consultant Job Planning Advisory Committee must review all proposed job plans for new consultant posts, as well as any job plans for existing consultants where the proposed new post would have an impact on current working practices. The date that the job plans were approved by the Committee and any comments which were made must be provided below.

Date of Approval	
Comments by the Committee	

13. Stakeholder Consultation and Involvement:

Identify the key stakeholders (both internal and external to the Trust) essential to the successful implementation of the business case; the extent to which each support the proposal, and where appropriate, ownership for the delivery of the benefits identified above. Where external stakeholder support is vital to the success of the business case (e.g. commitment to commission a service), append documentation (letter, e-mail, etc.) evidencing their commitment.

Examples of stakeholders include Lead Clinicians, support services (e.g. Systems & Network Services, Capital Planning re: accommodation), commissioners (e.g. Vale of York CCG, Scarborough & Ryedale CCG, etc), patients & public, etc. ***Please bear in mind that most business cases do have an impact on Facilities & Estates services.***

Stakeholder	Details of consultation, support, etc.
Mandatory Consultation	
Business Intelligence Unit	
Corporate Improvement Team	

Corporate Efficiency Team	
Workforce Team	
Commissioning Team	
Other Consultation	
Radiology Clinical Director, Radiology Consultants, Radiographers, Vascular Imaging Nursing team, Directorate Manager	Fully supportive of the Business Case for the many benefits this will bring for Service Users, patients and staff alike. Further, appreciation that the success of this Business Case is key to future service development in Imaging.

14. Sustainability

The Trust is committed to development of sustainable solutions in the delivery of its services, including minimising its carbon footprint. The following questions should be answered in the context of the impact of this business case has on the areas listed.

If assistance is required in assessing the sustainability impact of this business case, help is available from Brian Golding, Trust Energy Manager on (72)6498.

Will this Business Case:	Yes/No	If Yes, Explain How
Reduce or minimise the use of energy, especially from fossil fuels?	No	
Reduce or minimise Carbon Dioxide equivalent emissions from NHS activity?	No	
Reduce business miles?	Possibly	If the Trust lost the Vascular centre status current consultant staff may have to travel to other Trusts to undertake patient services
Reduce or minimise the production of waste, and/or increase the re-use and recycling of materials?	No	
Encourage the careful use of natural resources, such as water?	No	

15. Alliance Working

How does this business case support the Trust's stated objective of developing and enhancing the clinical alliance arrangements with Harrogate & District NHS Foundation Trust, and Hull and East Yorkshire Trust?

Regional Vascular centre serving the populations of Harrogate, York and Scarborough. This Business Case supports the Trust's objective in relation to enhancing the clinical alliance arrangements with Harrogate as evidenced by the recent engagement with key personnel from Harrogate and the discussions that took place around partnership working.

Vascular surgeon presence at Harrogate will be increased from one day per week to two days per week with the new appointment.

16. Integration

Integration of clinical and non-clinical services following the acquisition of the Scarborough & North East Yorkshire NHS Trust is a key priority for the Trust. How does this business case link into the Directorate's Integration plan? Have current non-integrated services discussed new appointments?

All vascular, interventional radiology imaging is provided within the current VIU this would ensure this continued.

The appointment of another vascular consultant surgeon means that provision of day case lists at Bridlington can be increased to weekly from fortnightly.

17. Impact on Community Services

Will this business case have an impact on Community Services and/or provide an opportunity to better integrate Acute and Community Services? How will this impact?

Will continue to provide current service to the community but with improved waiting time

18. Impact on the Ambulance Service:

	Yes	No
Are there any implications for the ambulance service in terms of changes to patient flow?		NO

If yes, please provide details including Ambulance Service feedback on the proposed changes:

19. Market Analysis:

Where the business case is predicated on securing new and/or increased business (and income), detail the evidence supporting the income projections.

Please refer to Business Case entitled Development of a North Yorkshire Vascular Centre at York Teaching Hospitals NHS Foundation Trust – 2011/45 for income projections

20. Financial Summary

20.1 Commissioning Team Review:

The Commissioning Team must review all business cases for consistency with PbR and other national commissioning guidance, and with regard to consistency with CCG, NHS England, and Local Authorities commissioning intentions. The date that the business case was reviewed by the CT together with any comments which were made must be provided below.

Date of Review	
Comments by CT	

20.2 Estimated Full Year Impact on Income & Expenditure:

Summarise the full year impact on income & expenditure for the specialty as a result of this business case. The figures should cross reference to the more detailed analysis on the accompanying 'Financial Pro Forma'.

	Baseline	Revised	Change
	£000	£000	£000
Capital Expenditure	0	1,800	1800
Income	0	492	492
Direct Operational Expenditure	0	663	663
EBITDA	0	-171	-171
Other Expenditure	0	164	164
I&E Surplus/ (Deficit)	0	-335	-335
Existing Provisions	n/a	0	0
Net I&E Surplus/ (Deficit)	0	-335	-335
Contribution (%)	#DIV/0!	-68.1%	-68.1%
Non-recurring Expenditure	n/a	0	0

Supporting financial commentary:

The capital cost is an estimate at this stage (estimated by service rather than Capital Planning) and includes building works, new equipment and infrastructure costs.

The assumed start date of the revenue consequences of this business case is 1st January 2017. The business case includes the 6th Vascular Consultant (and all associated costs / support) as well as the revenue resource required for the additional sessions within Theatre 10.

The revenue expenditure is based on 5 sessions per week performed in Theatre 10. There would therefore be spare capacity of 5 sessions per week which, if utilised, may attract further income and additional contribution.
The income included within this business case mainly relates to vascular surgery income from having additional Consultant capacity within the service (£386k). However £106k relates to additional vascular income resulting from the extra capacity created by Theatre 10.

Although this business case does not provide a contribution it is necessary to enable future developments within Cardiology and Vascular Surgery which are expected to make contributions to offset this investment. The final details regarding these future developments have not been finalised at this stage therefore there is an element of risk around this assumption.

21. Date:

January 2016

GAL/December 2014

York Teaching Hospital NHS
NHS Foundation Trust

BUSINESS CASE FINANCIAL SUMMARY

REFERENCE NUMBER:	2015-16/32
TITLE:	Development Of Theatre 10 To Provide Vascular Interventional Radiology Lab In Theatre Environment, Appointment Of 6th Interventional Radiologist and 6th Consultant Vascular Surgeon
OWNER:	James Haselden
AUTHOR:	Steven Mackell

Capital

	Total	Planned Profile of Change			
		2015/16	2016/17	2017/18	Later Years
	£'000	£'000	£'000	£'000	£'000
Expenditure	1,800	0	1,800	0	0

Capital Notes *(including reference to the funding source)* :
The capital cost is an estimate at this stage (estimated by service rather than Capital Planning) and includes building works, new equipment and infrastructure costs.

Revenue

	Total Change				Planned Profile of Change			
	Current	Revised	Change		2015/16	2016/17	2017/18	Later Years
	£'000	£'000	£'000	WTE	£'000	£'000	£'000	£'000
(a) Non-recurring			0		0	0	0	0
(b) Recurring								
Income								
NHS Clinical Income	0	492	492		0	123	492	492
Non-NHS Clinical Income								
Other Income	0							
Total Income	0	492	492		0	123	492	492
Expenditure								
Pay								
Medical - Vascular	0	166	166	1.25	0	41	166	166
Medical - Radiologist	0	69	69	0.50	0	17	69	69
Nursing	0	78	78	2.42	0	19	78	78
Other (please list):								
Admin & Clerical Staff	0	16	16	0.68	0	4	16	16
Support Staff	0	14	14	0.64	0	3	14	14
Radiographers	0	47	47	1.28	0	12	47	47
Support - Theatre 10	0	27	27		0	7	27	27
Support - Vascular	0	182	182		0	46	182	182
	0		0		0	0	0	0
	0	597	597	6.77	0	149	597	597
Non-Pay								
Drugs			0		0	0	0	0
Clinical Supplies & Services - Theatre 10	0	39	39		0	10	39	39
Clinical Supplies & Services - Vascular	0	27	27		0	7	27	27
General Supplies & Services			0		0	0	0	0
Other (please list):								
Establishment Expenses			0					
Unit Rental			0					
			0					
	0	66	66		0	16	66	66
Total Operational Expenditure	0	663	663		0	166	663	663
Impact on EBITDA	0	-171	-171	6.77	0	-43	-171	-171
Depreciation	0	132	132		0	33	132	132
Rate of Return	0	32	32		0	8	32	32
			0					
Overall impact on I&E	0	-335	-335	6.77	0	-84	-335	-335
								+ favourable (-) adverse
Less: Existing Provisions	n/a	0	0		0	0	0	0
Net impact on I&E	0	-335	-335		0	-84	-335	-335

Revenue Notes *(including reference to the funding source)* :
The assumed start date of the revenue consequences of this business case is 1st January 2017. The business case includes the 6th Vascular Consultant (and all associated costs / support) as well as the revenue resource required for the additional sessions within Theatre 10. The revenue expenditure is based on 5 sessions per week performed in Theatre 10. There would therefore be spare capacity of 5 sessions per week which, if utilised, may attract further income and additional contribution. The income included within this business case mainly relates to vascular surgery income from having additional Consultant capacity within the service (£386k). However £106k relates to additional vascular income resulting from the extra capacity created by Theatre 10. Although this business case does not provide a contribution it is necessary to enable future developments within Cardiology and Vascular Surgery which are expected to make contributions to offset this investment. The final details regarding these future developments have not been finalised at this stage therefore there is an element of risk around this assumption.

			Board of Directors Only
	Owner	Finance Manager	Director of Finance
Signed	James Haselden	Paul Roth	
Dated	7/1/16	7/1/16	

BUSINESS CASE - ACTIVITY & INCOME

Activity

	Total Change			Planned Profile of Change			
	Current	Revised	Change	2015/16	2016/17	2017/18	Later Years
Elective (Spells)	0	185	185	0	46	185	185
Non-Elective (Spells)							
Long Stay			0				
Short Stay	0	42	42	0	11	42	42
Outpatient (Attendances)							
First Attendances	0	210	210	0	53	210	210
Follow-up Attendances			0				
A&E (Attendances)			0				
Other (Please List):							
Unbundled Outpatient Radiology			0				
GP Direct Access Radiology			0				

Income

	Total Change			Planned Profile of Change			
	Current £'000	Revised £'000	Change £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	Later Years £'000
NHS Clinical Income							
Elective income							
Tariff income	0	270	270	0	67	270	270
Non-Tariff income			0				
Non-Elective income							
Tariff income	0	187	187	0	47	187	187
Non-Tariff income			0				
Outpatient							
Tariff income	0	35	35	0	9	35	35
Non-Tariff income			0				
A&E							
Tariff income			0				
Non-Tariff income			0				
Other							
Tariff income			0				
Non-Tariff income			0				
	0	**492**	**492**	**0**	**123**	**492**	**492**
Non NHS Clinical Income							
Private patient income			0				
Other non-protected clinical income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**
Other income							
Research and Development			0				
Education and Training			0				
Other income			0				
	0	**0**	**0**	**0**	**0**	**0**	**0**

York Teaching Hospital NHS Foundation Trust

Board of Directors – 27 January 2016

Monitor Return Q3

Action requested/recommendation

The Board is asked to approve the submission to Monitor for Q3.

Summary

The Trust is required to submit the quarter 3 return at the end of the month.

The position being submitted is as follows:

Financial sustainability Risk Rating (FRSS) The finance report and attached appendix shows the position.

Governance – there are a number of targets that have not been achieved this quarter including:

A&E 4 hour target
Cancer 62 Day for first treatment

(Please note that the figures included in the return for Cancer are un-validated and will be confirmed during November.)

Attached are copies of the submission documents.

The Trust continues to comply with the standard licence conditions as required by the Risk Assessment Framework and Monitor Provider Licence.

The Chair and Chief Executive will review the final supporting letter on behalf of the Board and confirm the letter prior to the submission being made to Monitor.

Strategic Aims	**Please cross as appropriate**
1. Improve quality and safety	☒
2. Create a culture of continuous improvement	☒
3. Develop and enable strong partnerships	☒
4. Improve our facilities and protect the environment	☒

Implications for equality and diversity

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

This report is for approval and contains no recommendations. It is therefore not expected to have any particular impact upon the requirements of, or on the protected groups identified by the Equality Act.

Reference to CQC outcomes

There are no references to CQC outcomes.

Progress of report	Prepared for presentation to the Board of Directors.
Risk	There are financial risk implications identified in the report.
Resource implications	There are financial resource implications identified in the report.
Owner	Patrick Crowley, Chief Executive
Author	Anna Pridmore, Foundation Trust Secretary
Date of paper	January 2016
Version number	Version 1

Summary of Financial Statements for York Teaching Hospital NHS Foundation Trust

	units	sense	Audited For PrevYE ending 31-Mar-15	Plan For Month ending 31-Dec-15	Actual For Month ending 31-Dec-15	Variance For Month ending 31-Dec-15	Plan For YTD ending 31-Dec-15	Actual For YTD ending 31-Dec-15	Variance For YTD ending 31-Dec-15	Plan For Year ending 31-Mar-16	Simple Forecast Year ending 31-Mar-16	Adjusted Forecast Year ending 31-Mar-16	Forecast Variance Year ending 31-Mar-16
Summary Income and Expenditure Account													
Operating income (inc in EBITDA)													
NHS Clinical income	£m	(+ve)	397.002	34.194	34.966	0.772	303.299	311.112	7.813	404.804	412.617	415.377	10.574
Non-NHS Clinical income	£m	(+ve)	2.679	0.231	0.301	0.070	2.082	2.115	0.033	2.776	2.809	2.820	0.044
Non-Clinical income	£m	(+ve)	52.031	3.777	4.285	0.507	33.996	38.013	4.017	45.328	49.345	50.467	5.139
Total	£m		**451.712**	**38.203**	**39.552**	**1.349**	**339.376**	**351.240**	**11.864**	**452.907**	**464.771**	**468.664**	**15.757**
Operating expenses (inc in EBITDA)													
Employee expense	£m	(-ve)	(300.151)	(24.628)	(26.670)	(2.043)	(220.769)	(239.307)	(18.538)	(295.371)	(313.909)	(318.551)	(23.180)
Non-Pay expense	£m	(-ve)	(136.422)	(11.929)	(12.734)	(0.804)	(106.766)	(108.351)	(1.585)	(142.483)	(144.068)	(143.487)	(1.004)
PFI / LIFT expense	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Total	£m		**(436.573)**	**(36.557)**	**(39.404)**	**(2.847)**	**(327.535)**	**(347.658)**	**(20.123)**	**(437.854)**	**(457.977)**	**(462.038)**	**(24.184)**
EBITDA	£m		15.139	1.645	0.147	(1.498)	11.841	3.582	(8.259)	15.053	6.794	6.627	(8.427)
EBITDA Margin %	%		3.35%	4.31%	0.37%	(3.93%)	3.49%	1.02%	(2.47%)	3.32%	1.46%	1.41%	(1.90%)
Operating income (exc from EBITDA)													
Donations and Grants for PPE and intangible assets	£m	(+ve)	0.634	0.050	0.062	0.012	0.450	0.554	0.104	0.600	0.704	0.739	0.139
Operating expenses (exc from EBITDA)													
Depreciation & Amortisation	£m	(-ve)	(10.850)	(0.917)	(0.917)	(0.000)	(8.250)	(8.250)	0.000	(11.000)	(11.000)	(11.000)	-
Impairment (Losses) / Reversals	£m	(+/-ve)	(3.757)	-	-	-	-	-	-	(0.300)	(0.300)	(0.300)	-
Restructuring costs	£m	(-ve)	(0.355)	-	(0.517)	(0.517)	-	(0.578)	(0.578)	-	(0.578)	(0.578)	(0.578)
Total	£m		**(14.962)**	**(0.917)**	**(1.434)**	**(0.517)**	**(8.250)**	**(8.828)**	**(0.578)**	**(11.300)**	**(11.878)**	**(11.878)**	**(0.578)**
Non-operating income													
Finance income	£m	(+ve)	0.163	0.008	0.008	(0.001)	0.075	0.108	0.033	0.100	0.133	0.143	0.043
Gain / (Losses) on asset disposals	£m	(+/-ve)	-	-	-	-	-	-	-	-	-	-	-
Gain on transfers by absorption	£m	(+ve)	-	-	-	-	(4.500)	(4.586)	(0.086)	(4.500)	(4.586)	(4.586)	(0.086)
Other non - operating income	£m	(+ve)	-	-	-	-	-	-	-	-	-	-	-
Total	£m		**0.163**	**0.008**	**0.008**	**(0.001)**	**(4.425)**	**(4.478)**	**(0.053)**	**(4.400)**	**(4.453)**	**(4.443)**	**(0.043)**
Non-operating expenses													
Interest expense (non-PFI / LIFT)	£m	(-ve)	(0.354)	(0.027)	(0.041)	(0.014)	(0.242)	(0.276)	(0.033)	(0.323)	(0.356)	(0.367)	(0.044)
Interest expense (PFI / LIFT)	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
PDC expense	£m	(-ve)	(6.238)	(0.587)	(0.587)	(0.000)	(5.280)	(5.280)	-	(7.040)	(7.040)	(7.040)	-
Other finance costs	£m	(-ve)	(0.023)	-	(0.010)	(0.010)	-	(0.019)	(0.019)	-	(0.019)	(0.019)	(0.019)
Non-operating PFI costs (e.g. contingent rent)	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Losses on transfers by absorption	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Other non-operating expenses (including tax)	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Total	£m		**(6.615)**	**(0.614)**	**(0.638)**	**(0.024)**	**(5.522)**	**(5.575)**	**(0.053)**	**(7.363)**	**(7.416)**	**(7.427)**	**(0.064)**
Surplus / (Deficit) after tax	£m		**(5.641)**	**0.174**	**(1.855)**	**(2.028)**	**(5.906)**	**(14.744)**	**(8.838)**	**(7.410)**	**(16.248)**	**(16.381)**	**(8.972)**
Profit/(loss) from discontinued Operations, Net of Tax	£m	(+/-ve)	-	-	-	-	-	-	-	-	-	-	-
Surplus / (Deficit) after tax from Continuing Operations	£m		**(5.641)**	**0.174**	**(1.855)**	**(2.028)**	**(5.906)**	**(14.744)**	**(8.838)**	**(7.410)**	**(16.248)**	**(16.381)**	**(8.972)**
Memorandum Lines:													
Surplus / (Deficit) before impairments and transfers	£m		(1.884)	0.174	(1.855)	(2.028)	(1.406)	(10.159)	(8.753)	(2.610)	(11.362)	(11.496)	(8.886)
One off income/costs	£m		(4.112)	-	(0.517)	(0.517)	(4.500)	(5.164)	(0.664)	(4.800)	(5.464)	(5.464)	(0.664)
Normalised Surplus / (Deficit)	£m		(1.529)	0.174	(1.338)	(1.511)	(1.406)	(9.581)	(8.175)	(2.610)	(10.784)	(10.918)	(8.308)
Normalised Surplus / Deficit Margin %	%		(0.34%)	0.45%	(3.38%)	(3.83%)	(0.41%)	(2.72%)	(2.31%)	(0.58%)	(2.32%)	(2.33%)	(1.70%)
Summary Statement of Financial Position													
Non-current Assets													
Intangible assets	£m	(+ve)	1.716	2.931	1.827	(1.104)	2.931	1.827	(1.104)	3.403	2.299	2.299	(1.104)
Property, Plant & Equipment	£m	(+ve)	225.882	229.900	229.191	(0.709)	229.900	229.191	(0.709)	233.081	232.372	232.372	(0.709)
On-balance sheet PFI	£m	(+ve)	-	-	-	-	-	-	-	-	-	-	-
Other	£m	(+ve)	1.087	1.087	1.087	-	1.087	1.087	-	1.087	1.087	1.087	-
Total	£m		**228.685**	**233.918**	**232.105**	**(1.813)**	**233.918**	**232.105**	**(1.813)**	**237.571**	**235.758**	**235.758**	**(1.813)**
Current Assets													
Cash and cash equivalents	£m	(+ve)	18.493	21.135	9.814	(11.321)	21.135	9.814	(11.321)	18.465	7.144	7.144	(11.321)
Other current assets	£m	(+ve)	28.123	27.273	35.045	7.772	27.273	35.045	7.772	27.273	35.045	35.045	7.772
Total	£m		**46.616**	**48.408**	**44.859**	**(3.549)**	**48.408**	**44.859**	**(3.549)**	**45.738**	**42.189**	**42.189**	**(3.549)**
Current Liabilities													
Overdrafts and drawdowns in committed facilities	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
PFI / LIFT leases	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Other borrowings	£m	(-ve)	(1.313)	(2.007)	(2.019)	(0.012)	(2.007)	(2.019)	(0.012)	(2.001)	(2.013)	(2.013)	(0.012)
Other current liabilities	£m	(-ve)	(32.483)	(34.163)	(41.901)	(7.738)	(34.163)	(41.901)	(7.738)	(33.657)	(41.395)	(41.395)	(7.738)
Total	£m		**(33.796)**	**(36.170)**	**(43.920)**	**(7.750)**	**(36.170)**	**(43.920)**	**(7.750)**	**(35.658)**	**(43.408)**	**(43.408)**	**(7.750)**

Non-current Liabilities													
PFI / LIFT leases	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Other borrowings	£m	(-ve)	(11.539)	(19.096)	(17.883)	1.213	(19.096)	(17.883)	1.213	(20.095)	(18.882)	(18.882)	1.213
Other non-current liabilities	£m	(-ve)	(1.115)	(1.115)	(1.055)	0.060	(1.115)	(1.055)	0.060	(1.115)	(1.055)	(1.055)	0.060
Total	£m		**(12.654)**	**(20.211)**	**(18.938)**	**1.273**	**(20.211)**	**(18.938)**	**1.273**	**(21.210)**	**(19.937)**	**(19.937)**	**1.273**
Reserves	£m	(+ve)	228.851	225.945	214.107	(11.838)	225.945	214.107	(11.838)	226.441	214.603	214.603	(11.838)
Summary Statement of Cash Flows													
Surplus (Deficit) from Operations	£m		0.811	0.779	(1.225)	(2.004)	4.041	(4.691)	(8.733)	4.353	(4.379)	(4.512)	(8.865)
Operating activities													
Non-operating and non-cash items in operating surplus/(deficit)	£m	(+/-ve)	14.610	0.916	0.363	(0.553)	8.250	7.696	(0.554)	11.300	10.746	10.746	(0.554)
Operating Cash flows before movements in working capital	£m		**15.421**	**1.695**	**(0.862)**	**(2.557)**	**12.291**	**3.005**	**(9.287)**	**15.653**	**6.367**	**6.234**	**(9.419)**
Movements in working capital	£m	(+/-ve)	9.240	(0.029)	1.462	1.491	(0.029)	0.792	0.821	0.052	0.873	0.873	0.821
Increase/(Decrease) in non-current provisions	£m	(+/-ve)	-	-	(0.096)	(0.096)	-	(0.060)	(0.060)	-	(0.060)	(0.060)	(0.060)
Net cash inflow/(outflow) from operating activities	£m		**24.661**	**1.666**	**0.504**	**(1.162)**	**12.262**	**3.737**	**(8.526)**	**15.705**	**7.180**	**7.047**	**(8.658)**
Investing activities													
Capital Expenditure (Accruals basis)	£m	(-ve)	(22.280)	(2.225)	(1.854)	0.371	(17.983)	(16.208)	1.775	(23.186)	(21.411)	(21.411)	1.775
Increase/(decrease) in Capital Creditors	£m	(+/-ve)	(1.977)	-	(0.794)	(0.794)	-	(0.943)	(0.943)	1.173	0.230	0.230	(0.943)
Proceeds on disposal of PPE, intangible assets and investment property	£m	(+ve)	-	-	-	-	-	0.240	0.240	0.500	0.740	0.740	0.240
Other cash flows from investing activities	£m	(+/-ve)	0.163	0.009	0.558	0.549	0.075	0.657	0.582	0.100	0.682	0.682	0.582
Net cash inflow/(outflow) from investing activities	£m		**(24.094)**	**(2.216)**	**(2.090)**	**0.126**	**(17.908)**	**(16.254)**	**1.654**	**(21.413)**	**(19.759)**	**(19.759)**	**1.654**
Financing activities													
Public Dividend Capital repaid	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Repayment of borrowings	£m	(-ve)	(1.125)	(0.375)	(0.377)	(0.002)	(1.252)	(1.254)	(0.002)	(1.258)	(1.260)	(1.260)	(0.002)
Capital element of finance lease rental payments	£m	(-ve)	(0.107)	-	-	-	(0.054)	(0.054)	-	(0.054)	(0.054)	(0.054)	-
Interest element of finance lease rental payments	£m	(-ve)	-	-	-	-	-	-	-	-	-	-	-
Interest paid on borrowings	£m	(-ve)	(0.333)	(0.026)	(0.078)	(0.052)	(0.243)	(0.363)	(0.120)	(0.324)	(0.444)	(0.444)	(0.120)
Other cash flows from financing activities	£m	(+/-ve)	(5.771)	4.157	1.257	(2.900)	9.836	5.399	(4.437)	7.316	2.879	2.879	(4.437)
Net cash inflow/(outflow) from financing activities	£m		**(7.336)**	**3.756**	**0.802**	**(2.954)**	**8.287**	**3.728**	**(4.559)**	**5.680**	**1.121**	**1.121**	**(4.559)**
Opening cash and cash equivalents less bank overdraft	£m	(+/-ve)	25.262	17.929	10.488	(7.441)	18.493	18.493	-	18.493	18.493	18.493	-
Net cash increase / (decrease)	£m		(6.769)	3.206	(0.784)	(3.990)	2.641	(8.789)	(11.431)	(0.028)	(11.458)	(11.591)	(11.563)
Changes due to transfers by absorption	£m	(+/-ve)	-	-	-	-	-	-	-	-	-	-	-
Closing cash and cash equivalents less bank overdraft	£m		**18.493**	**21.134**	**9.704**	**(11.431)**	**21.134**	**9.704**	**(11.431)**	**18.465**	**7.035**	**6.902**	**(11.563)**
Financial Sustainability Risk Rating													
Capital Service Cover													
Revenue Available for Capital Service	£m		15.302				11.916	3.690	(8.226)	15.153	6.927	6.770	(8.384)
Capital Service	£m		(7.847)				(6.828)	(6.883)	(0.055)	(8.675)	(8.730)	(8.741)	(0.066)
Capital Service Cover metric	0.0x		1.95				1.75	0.54	(1.21)	1.75	0.79	0.77	(0.97)
Capital Service Cover rating	Score		**3**				**2**	**1**		**2**	**1**	**1**	
Liquidity													
Working Capital for FSRR	£m	(+/-ve)	5.743				5.398	(7.097)	(12.495)	3.240	(9.255)	(9.255)	(12.495)
Operating Expenses within EBITDA, Total	£m		(436.573)				(327.535)	(347.658)	(20.123)	(437.854)	(457.977)	(462.038)	(24.184)
Liquidity metric	Days		4.736				4.450	(5.512)	(9.961)	2.664	(7.275)	(7.211)	(9.875)
Liquidity rating	Score		**4**				**4**	**3**		**4**	**2**	**2**	
I&E Margin													
Normalised Surplus/(Deficit)	£m	(+/-ve)	(1.529)				(1.406)	(9.581)	(8.175)	(2.610)	(10.784)	(10.918)	(8.308)
Adjusted Total Income for FSRR	£m	(+ve)	452.509				339.901	351.902	12.001	453.607	465.608	469.547	15.939
I&E Margin	%		(0.34%)				(0.41%)	(2.72%)	(2.31%)	(0.58%)	(2.32%)	(2.33%)	-1.70%
I&E Margin rating	Score		**2**				**2**	**1**		**2**	**1**	**1**	
I&E Margin Variance													
I&E Margin	%						(0.41%)	(2.72%)	(2.31%)	(0.58%)	(2.32%)	(2.33%)	-1.70%
I&E Margin Variance From Plan	%		-1.12%				(1.12%)	-2.31%		(1.12%)	(1.74%)	(1.75%)	
I&E Margin Variance From Plan rating	Score						**2**	**1**		**2**	**2**	**2**	
Overall Financial Sustainability Risk Rating	Score						**3**	**2**		**3**	**2**	**2**	
Continuity of Service Risk Rating	Score		**4**										
CIPs													
CIPs as a percentage of opex within EBITDA less PFI expenses	%		6.51%	5.55%	5.56%	0.02%	5.57%	4.91%	(0.66%)	5.56%	5.06%	5.28%	-0.30%
CIPs	£m	(+ve)	30.414	2.147	2.322	0.175	19.317	17.961	(1.356)	25.755	24.400	25.755	-

Declaration of risks against healthcare targets and indicators for 201516 by York Teaching Hospital NHS Foundation Trus

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key:

must complete
may need to complete

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Quarter 1 Performance	Quarter 1 Declaration	Quarter 2 Performance	Quarter 2 Declaration	Quarter 3 Performance	Quarter 3 Declaration
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	92.8%	Achieved	93.8%	Achieved	93.6%	Achieved
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	88.3%	Not met	91.5%	Not met	87.1%	Not met
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	87.8%	Achieved	85.2%	Achieved	83.8%	Not met
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	98.4%	Achieved	90.0%	Achieved	97.7%	Achieved
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation		0.0%		0.0%		0.0%	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation		0.0%		0.0%		0.0%	
Cancer 31 day wait for second or subsequent treatment - surgery	94%	94.4%	Achieved	95.3%	Achieved	95.2%	Achieved
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	99.6%	Achieved	99.6%	Achieved	100.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Cancer 31 day wait from diagnosis to first treatment	96%	96.2%	Achieved	98.9%	Achieved	99.2%	Achieved
Cancer 2 week (all cancers)	93%	93.9%	Achieved	91.9%	Not met	95.2%	Achieved
Cancer 2 week (breast symptoms)	93%	91.4%	Not met	94.0%	Achieved	94.8%	Achieved
Care Programme Approach (CPA) follow up within 7 days of discharge	95%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Care Programme Approach (CPA) formal review within 12 months	95%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Admissions had access to crisis resolution / home treatment teams	95%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Meeting commitment to serve new psychosis cases by early intervention teams OLD measure - use until Q1 2016/17	95%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Ambulance Category A 8 Minute Response Time - Red 1 Calls	75%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Ambulance Category A 8 Minute Response Time - Red 2 Calls	75%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Ambulance Category A 19 Minute Transportation Time	95%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
C.Diff due to lapses in care (YTD)	44.25	21	Not met	21	Not met	41	Achieved
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)		21		35		50	
C.Diff cases under review		21		14		9	
Minimising MH delayed transfers of care	<=7.5%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Meeting commitment to serve new psychosis cases by early intervention teams NEW measure (scored from Q4 2015/16)	50%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Improving Access to Psychological Therapies - Patients referred within 6 weeks NEW measure (scored from Q3 2015/16)	75%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Improving Access to Psychological Therapies - Patients referred within 18 weeks NEW measure (scored from Q3 2015/16)	95%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Data completeness, MH: identifiers	97%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Data completeness, MH: outcomes	50%	0.0%	Not relevant	0.0%	Not relevant	0.0%	Not relevant
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	N/A	Achieved	N/A	Achieved	N/A	Achieved
Community care - referral to treatment information completeness	50%	100.0%	Achieved	100.0%	Achieved	100.0%	Achieved
Community care - referral information completeness	50%	69.6%	Achieved	70.8%	Achieved	75.9%	Achieved
Community care - activity information completeness	50%	95.5%	Achieved	95.5%	Achieved	95.1%	Achieved
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A		No		No		No
Date of last CQC inspection	N/A		31/03/2015		31/03/2015		31/03/2015
CQC compliance action outstanding (as at time of submission)	N/A		No		No		No
CQC enforcement action within last 12 months (as at time of submission)	N/A		No		No		No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No		No		No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No		Yes		Yes
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No		No		No
Overall rating from CQC inspection (as at time of submission)	N/A		N/A		Requires improvement		Requires improvement
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		No		No		No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No		No		No
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A		N/A		N/A		N/A
Results left to complete:			0		0		0
Checks Count:							
Checks left to clear:							OK
Service Performance Score							

Click to go to index

In Year Governance Statement from the Board of York Teaching Hospital NHS Foundati

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)	Board Response
For finance, that:	
The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.	
The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.	Confirmed
For governance, that:	
The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Confirmed
Otherwise:	
The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) which have not already been reported.	Confirmed
Consolidated subsidiaries:	
Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature	Sign Here.	Signature	Sign Here.
Name	Susan Symington	Name	Patrick Crowley
Capacity	Chairman	Capacity	Chief Executive
Date	27-Jan	Date	27-Jan-16

Responses still to complete: 1

Notes:

Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.
In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.
This may include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.
Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C